HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE

Digitized by the Internet Archive
in 2016

https://archive.org/details/imjillinoismedic1451illi

Illinois Medical Journal

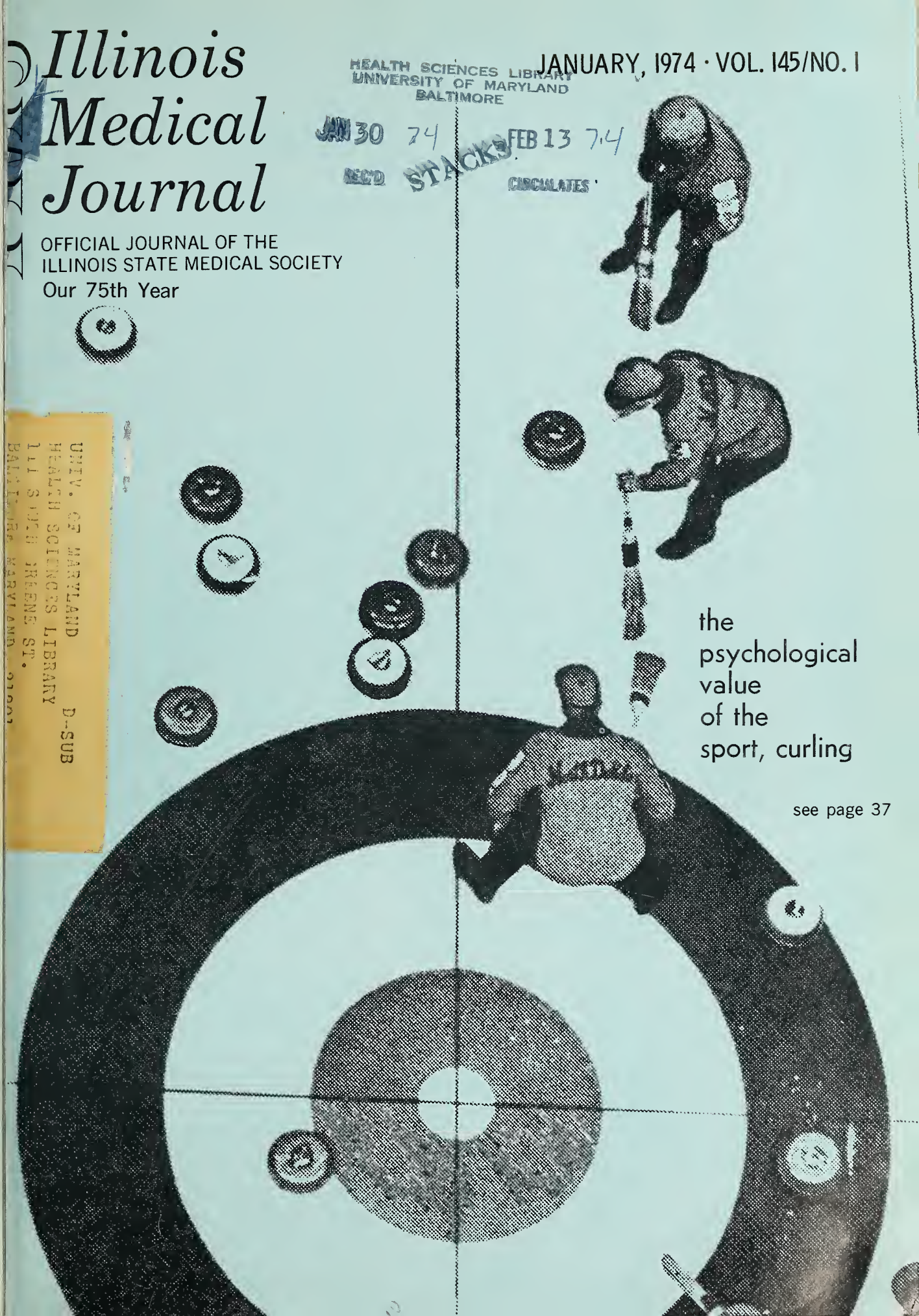
JANUARY, 1974 · VOL. 145/NO. 1

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE

JAN 30 74 FEB 13 74
REC'D STACKS CIRCULATES

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY
Our 75th Year

UNIV. OF MARYLAND D-SUB
HEALTH SCIENCES LIBRARY
111 S. GREENE ST.
BALTIMORE MARYLAND 21201



the psychological value of the sport, curling

see page 37

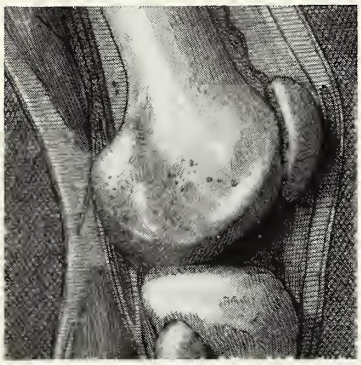
HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE

JAN 30 REC'D

FEB 13 CIRCULATES

WHEN FLU HITS AND HURTS

HERE Muscles and joints



Wherever it hurts, Empirin Compound with Codeine usually provides the symptomatic relief needed.

HERE Headache

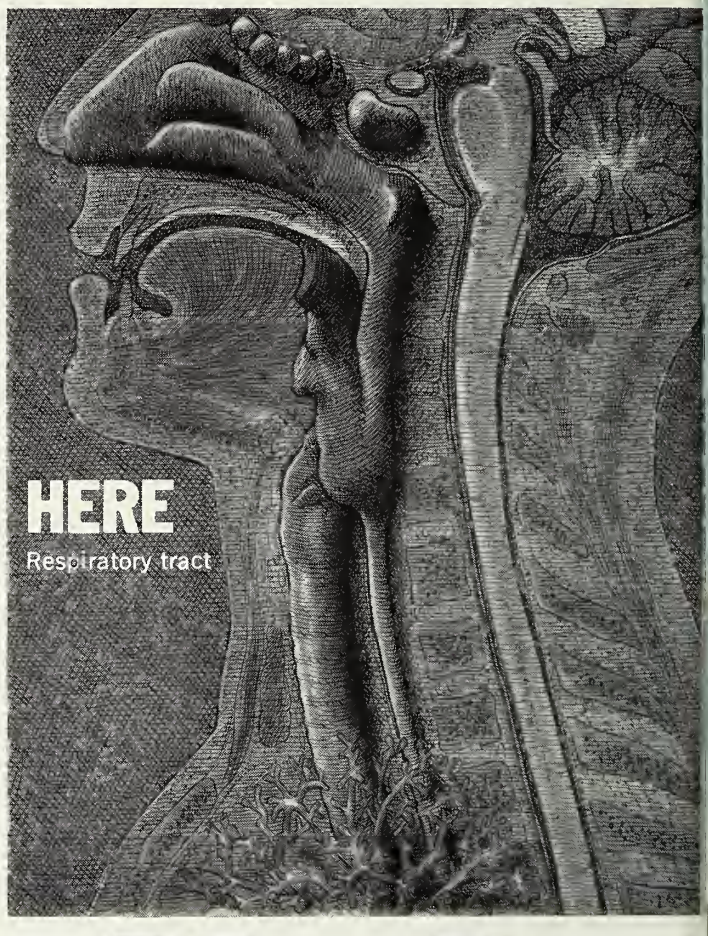


In flu and associated respiratory infection, Empirin Compound with Codeine provides an antitussive bonus in addition to relief of pain and bodily discomfort.

℞ **prescribing convenience:** up to 5 refills in 6 months, at your discretion (unless restricted by state law); by telephone order in many states.

Empirin Compound with Codeine **No. 3,** codeine phosphate* 32.4 mg. (gr. ½); **No. 4,** codeine phosphate* 64.8 mg. (gr. 1) *Warning—may be habit-forming. Each tablet also contains: aspirin gr. 3½, phenacetin gr. 2½, caffeine gr. ½.

Wellcome / Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



EMPIRIN COMPOUND ℞ CODEINE

#3, codeine phosphate* (32.4 mg.) gr. ½
#4, codeine phosphate* (64.8 mg.) gr. 1

BLUE SHIELD REPORT FOR Illinois Physicians

Blue Shield Reciprocity Program to Expand in 1974

A sizable increase in membership enrollment in the Blue Shield Reciprocity Program will occur in 1974. More than 2¼ million members have been enrolled since it was developed by the National Association of Blue Shield Plans in March, 1972 and NABSP estimates that enrollment will be expanded by another 2½ million or more before the end of 1974.

The System enables Illinois physicians to bill and receive payments directly from the Blue Shield Plan of Illinois Medical Service for services provided to out-of-state members having this special program.

Basis of Payment

Payment under the Reciprocity Program is made on the 100% Usual and Customary basis. A physician receives 100% of his usual fee when his fee is "within the range of usual fees charged by physicians of similar training and experience" for services covered under the Reciprocity contract. Because the claims will be processed by Illinois Blue Shield without delay for membership verification, the phycian receives payment promptly.

Membership Identification

Members enrolled in the program will be easily identified by the special identification card which has a double-pointed red arrow in the upper left corner and a series of three numbers preceded by the letter "N" within the arrow. The number indicates the "Home Plan" of the member.

When a physician treats a patient having this special card, he files for benefits in the same way he would for an Illinois member with one exception: Both the letter "N" and the code numbers in the arrow, *and* the subscriber's identification number must be entered in the group and subscriber number boxes on the Physician's Service Report form. This enables our claims examiners to identify the claim as a Reciprocity System claim and allows us to coordinate the information with the Home Plan after payment is made. (Example shown on following page).

Advantages to Illinois Physicians

The Program has a number of advantages to Illinois physicians:

(1) Payment is guaranteed. As long as the necessary information is recorded properly on the Physician's Service Report, the claim can be processed and payment made to the physician.

(2) No contact is necessary with another Blue Shield Plan, nor is it necessary to complete a service report form unfamiliar to the physician or his medical assistant. Claims are submitted to Illinois Blue Shield using our own Service Reports.

(3) The physician need not wait for payment while another Plan contacts Illinois Blue Shield about medical charges in our area. We can make payment promptly using the physician's fee data of record.

Covered Services

Benefits under the Reciprocity System include:

- *Surgery*—Wherever performed, including operative or cutting procedures, treatment of fractures or dislocations and endoscopic procedures.
- *Assistant Surgeon*—Coverage when such service is certified as necessary and house staff, interns or residents are not available for such service.
- *Anesthesia*—Wherever performed for covered services when administered by a physician other than the operating physician or his assistant.
- *Radiation Therapy*—Wherever performed for services provided by a physician for X-ray, radium or radioactive isotopes, including rental of materials unless supplied by a hospital or other institution.
- *Diagnostic X-ray*—Including interpretation and report, while the member is a registered bed patient in a hospital when such examination is consistent with the diagnosis, or in the outpatient department of a hospital or in a physician's office when the examination is performed as a direct result of an injury.
- *Laboratory and Pathology*—Examination in a hospital when consistent with the diagnosis or in

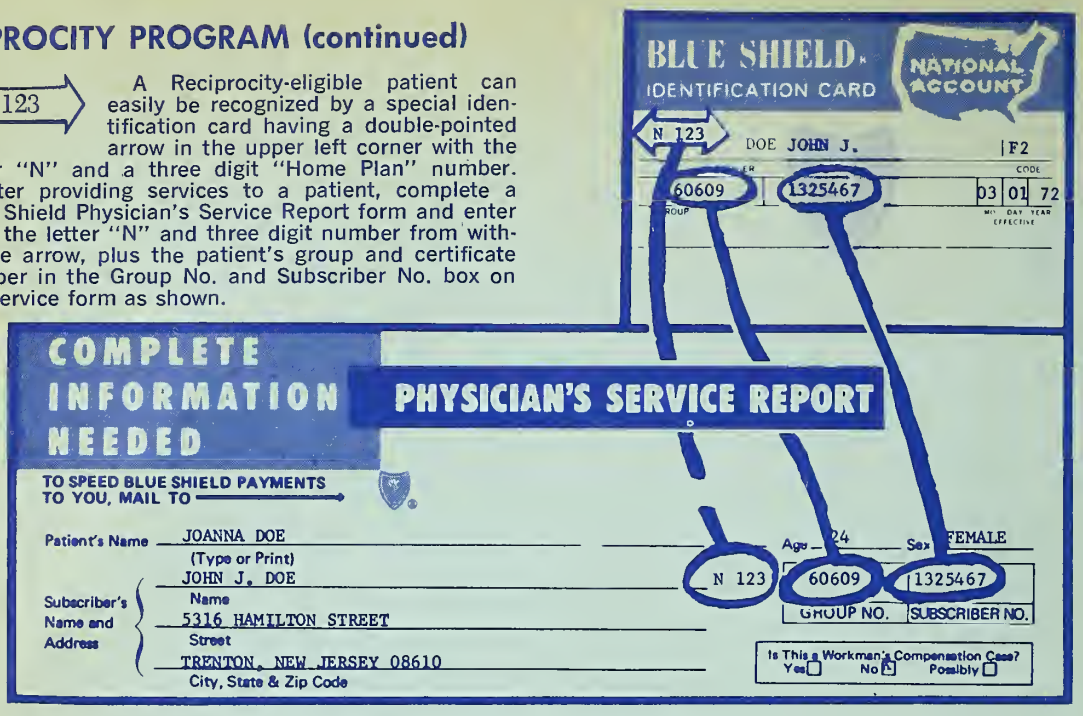
(Continued on following page)

RECIPROCITY PROGRAM (continued)

N 123

A Reciprocity-eligible patient can easily be recognized by a special identification card having a double-pointed arrow in the upper left corner with the letter "N" and a three digit "Home Plan" number.

After providing services to a patient, complete a Blue Shield Physician's Service Report form and enter both the letter "N" and three digit number from within the arrow, plus the patient's group and certificate number in the Group No. and Subscriber No. box on the service form as shown.



the outpatient department of a hospital or in a physician's office when the examination is performed as a direct result of an injury.

- *In-Hospital Medical Care*—Any medical treatment by an attending physician for a condition not related to surgical or maternity care for the first 30* days for each hospital admission. Concurrent medical care benefits will be provided for surgical care patients if the service is rendered by another physician for medical complications.
- *Pulmonary Tuberculosis, Mental Disorders, Drug Addiction and Chronic Alcoholism*—Coverage for the first 30* days of each hospital admission.
- *Outpatient Emergency Care*—Necessary services performed by a physician wherever performed for an accidental injury or for the first visit at the onset of a medical emergency.
- *Consultations*—Services of another physician when requested by the attending physician for advice in diagnosis or treatment of a condition which requires such special skill or knowledge while the member is a bed patient in a hospital.

The Reciprocity System does not cover maternity services, dental or nursing services, appliances or supplies, operations for cosmetic purposes, care obtained in U.S. Government hospitals, care obtained without cost, Workmen's Compensation cases, services primarilarly for diagnostic purposes, or claims for Medicare beneficiaries.

If you have an questions regarding the Reciprocity Program, contact your Professional Relations Representative or the Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 233 North Michigan Ave., Chicago, Illinois 60601—(312) 661-4489.

**Number of days varies according to individual group contract.*

ASK BLUE SHIELD . . . ABOUT MEDICARE

Part B "Carry-Over" Deductible Helps Meet Medical Expenses

Persons eligible for Part B Medicare benefits, including the disabled under age 65, must meet a deductible of $60 in the 1974 calendar year. Payment is made for covered services after the Part B deductible is satisfied. Even if a beneficiary is eligible for program benefits for only a portion of the year, the entire deductible must be met.

To help a beneficiary who might otherwise have to meet the deductible twice in a relatively short period of time, the "carry-over" deductible was established.

Expenses incurred in the last three months of the year which are applied to the deductible for that year, may also be applied toward the deductible for the following year.

For example, a patient incurred a charge of $40 in November, 1973 that was applied to the 1973 deductible of $60. The $40 may also be applied to the 1974 deductible leaving an unmet deductible of $20 in 1974. Covered expenses carried over from 1973 to 1974 cannot exceed $60 and non-covered services do not count toward meeting the deductible.

If a patient meets the full cash deductible through covered expenses prior to October 1, charges incurred after October 1 cannot be applied toward the annual deductible and the entire $60 deductible must be met for the following year.

(This report is a service to the physicians of Illinois)

IMJ
Illinois Medical Journal

JANUARY, 1974 Vol. 145, No. 1 CONTENTS

Clinical Articles

29 Probable 16 Year Course in a Patient with Thrombotic Thrombocytopenic Purpura
Dee C. Boswell, M.D. and Gregorio Sierra, M.D.

32 Failure of Corticosteroid in the Treatment of Duchenne (Pseudo-Hypertrophic) Muscular Dystrophy
Report of a Clinically Matched Three Year Double-Blind Study
Irwin M. Siegel, M.D., Joseph E. Miller, M.D., and Robert D. Ray, M.D.

34 A Perspective of Peripheral Health Care
B. D. Reeves, M.D., S. McCue, M.D., A. Wagner, Jr., M.D. and T. W. McElin, M.D., M.S.

37 The Psychological Value of the Sport, Curling
Thomas N. Davis, III, M.D.

40 Aneurysm of the Gastroduodenal Artery: A Cause of Gastrointestinal Bleeding
James E. Weese, M.D.

43 Brown Recluse Spider Bite
Increasing Incidents in Northern Illinois
Robert Simmons, M.D., and John W. Curtin, M.D., F.A.C.S.

47 Common Problems in High Risk Nurseries
Rosita S. Pildes, M.D.

58 Cardiovascular Collapse During Gynecological Laparoscopy
A. D. Ivankovich, M.D., R. F. Albrecht, M.D., B. Zahed, M.D., and R. F. Bonnet, M.D.

Surgical Grand Rounds

68 Tuberculosis of Kidney
John M. Beal, M.D.

History of Medicine

62 Marcus P. Hatfield—The First Pediatrician at Northwestern
Ronald D. Greenwood, M.D.

(Contents continued overleaf)

CONTENTS (continued)

Features

10 President's Page
21 Editorial
26 Clinics For Crippled Children
36 View Box
52 Doctor's News
64 EKG of the Month
72 Pulse of the Doctor's Wife
74 ISMS Guide to Continuing Medical Education
80 Physician Recruitment
83 Obituaries

(Cover by Mike Ahearn; picture courtesy of North American Curling News)

Staff

Editor **Theodore R. Van Dellen, M.D.**

Managing editor **Richard A. Ott**

Assistant editor **Joyce Gallagher**

Executive administrator **Roger N. White**

PUBLICATIONS COMMITTEE

Jaeob E. Reisch, M.D., Springfield, *Chairman*
Eugene T. Hoban, M.D., Oak Park
Frederick E. Weiss, M.D., Harvey
James A. McDonald, M.D., Geneva
Warren W. Young, M.D., Crete

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Medical Progress: Harvey Kravitz, M.D., Skokie
Contributor in Maternal Death Studies: Robert Hartman, M.D.
Contributor in Pediatrie Perplexities: Ruth A. Seeler, M.D., Chicago
Contributor in Trauma Medicine: David Boyd, M.D.C.M., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood

ILLINOIS STATE MEDICAL SOCIETY

360 N. Michigan Ave., Chicago, 60601

OFFICERS

Willard C. Scrivner, M.D., President
6600 West Main, Belleville 62223

Fredric D. Lake, M.D., President-Elect
1041 Michigan Avenue, Evanston 60202

Paul W. Sunderland, M.D., 1st Vice-President
214 N. Sangamon St., Gibson City 60936

Charles J. Weigel, M.D., 2nd Vice-President
7579 Lake Street, River Forest 60305

Jacob E. Reisch, M.D., Secretary-Treasurer
1129 S. 2nd Street, Springfield 62704

HOUSE OF DELEGATES

Andrew J. Brislen, M.D., Speaker of the House
6060 S. Drexel Blvd., Chicago 60637

James A. MeDonald, M.D., Vice-Speaker
13 South Second Street, Geneva 60134

TRUSTEES

Chairman of the Board: William M. Lees, M.D.
6518 North Nokomis, Lincolnwood 60646

1st District: 1974, Joseph L. Bordenave, M.D.
1665 South Street, Geneva 60134

2nd District: 1974, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364

3rd District: 1976, David S. Fox, M.D.
20829 Greenwood Center Court, Olympia Fields 60461

3rd District: 1976, Robert T. Fox, M.D.
2136 Robin Crest, Glenview 60025

3rd District: 1975, Eugene T. Hoban, M.D.
6429 North Avenue, Oak Park 60302

3rd District: 1975, Joseph H. Skom, M.D.
707 Fairbanks Ct., Chicago 60611

3rd District: 1974, William M. Lees, M.D.
6518 North Nokomis, Lincolnwood 60646

3rd District: 1974, George Shropshear, M.D.
1525 East 53rd Street, Chicago 60615

3rd District: 1974, Philip G. Thomsen, M.D.
13826 Lincoln Avenue, Dolton 60419

3rd Distriet: 1976, Frederick E. Weiss, M.D.
15643 Lincoln, Harvey 60426

3rd District: 1975, Warren Young, M.D.
3450 Haweswood Drive, Crete 60417

4th District: 1976, Fred Z. White, M.D.
723 North 2nd Street, Chillicothe 61523

5th Distriet: 1976, A. Edward Livingston, M.D.
326 Fairway Drive, Bloomington 61701

6th District: 1975, Mather Pfeiffenberger, M.D.
State and Wall Streets, Alton 62002

7th District: 1976, Arthur F. Goodyear, M.D.
142 East Prairie, Decatur 62523

8th District: 1976, Eugene P. Johnson, M.D.
P.O. Box 68, Casey 62420

9th Distriet: 1975, Warren D. Tuttle, M.D.
203 North Vine Street, Harrisburg 62946

10th District: 1975, Herbert Dexheimer, M.D.
301 S. Illinois, Belleville 62220

11th District: 1974, Joseph R. O'Donnell, M.D.
444 Park, Glen Ellyn 60137

Trustee-At-Large: Frank J. Jirka, Jr., M.D.
1507 Keystone, River Forest 60305

Microfilm eopies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/ Clinical Practice.*

Published by the Illinois State Medieal Soeiety, 360 N. Michigan Ave., Chieago, Ill. 60601 (312-782-1654)

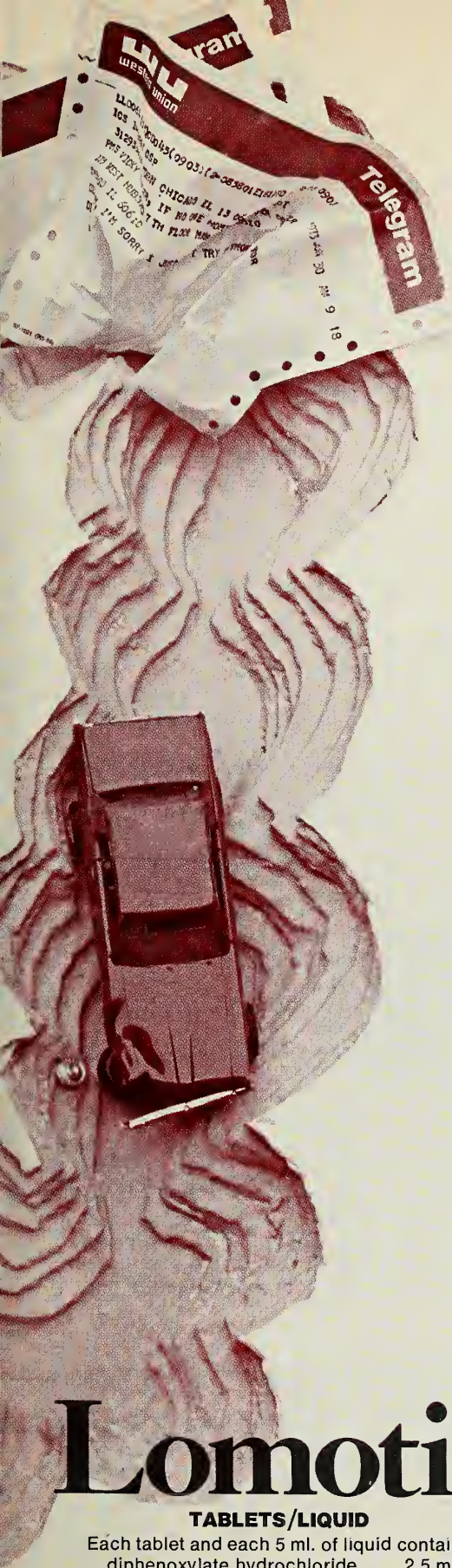
Copyright, 1973. The Illinois State Medical Society.

Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $7.50 per year for all foreign countries included in the Universal Postal Union. Canada $5.50. U.S. Single current copies available at 75c.

Second class postage paid at Chicago, Ill. When moving please notify Journal offiee of new address ineluding old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutieal advertising must be approved by the ISMS Publieations Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preeeding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which refleet the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not neeessarily represent those of the Society; any connection with official policies is coincidental.



Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

takes care of the gut issue in irritable colon

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co., Medical Department
Box 5110, Chicago, Illinois 60680

President's Page



Conspiracy of Silence?

Medicine often has been charged with condoning a "conspiracy of silence."

The accusation is harsh, and most will argue that it is unfounded.

The charge was leveled again last month by some members of the Illinois Legislative Investigating Commission which is looking into cases of alleged prescribing abuses which contribute to illegal drug traffic. These Commission members contend that medicine is doing a less-than-effective "police" job because physicians are reluctant to initiate action against colleagues who are practicing illegally.

Some Commission members appear to have a distorted view of "policing" responsibilities. Although there are certain review mechanisms within organized medicine that can lead to punitive action, our profession cannot suspend or revoke a physician's license. Licensure is a state function. Since 1968, the state has revoked only eight licenses and suspended two others.

During a Commission hearing last month, the first of several expected around the state, more than 60 MDs were identified in sworn testimony as having written prescriptions enabling abusers to illegally obtain drugs. Undercover agents have targeted other MDs for further investigation.

We are confronted with a very serious situation: medicine's image is being tarnished . . . by physicians!

If results of subsequent hearings parallel those of the first, the Commission's report to the General Assembly later this year could foster attempts to place further regulatory controls upon the practice of medicine. We could be faced with increased "police" activities by various enforcement agencies, and restrictive controls upon prescribing abilities.

The present state disciplinary system is characterized by glaring deficiencies. The limited effectiveness of the Department of Registration and Education's (R&E) Office of Professional Supervision (OPS) could be attributed in part to the lack of adequate staff and lack of a basic set of written procedures and regulations. The Medical Examining Committee, which is *not* a disciplinary board, can act only in cases referred to it by the OPS.

It appears, however, that several Commission members have chosen to overlook these deficiencies in favor of attacking the medical profession. They also seem content to ignore reports that R&E has failed to act upon numerous complaints, and addressed itself to others with glacier-like speed. It is reported that eight years passed before R&E took final action in one case involving misuse of medical prescriptions to obtain drugs for abuse—the very matter which the Commission is investigating. The only action was to revoke the privilege of writing prescriptions for controlled substances. In many cases an "informal hearing" involving an investigator or the OPS results in an "understanding" and precludes any disciplinary action.

Apathetic responses by R&E to complaints reported by organized medicine and others hardly can be termed a bold step toward solving a problem of vital concern to our profession.

Illinois needs a strong disciplinary system; a concept physicians have been advocating for many years.

A 1969 survey of ISMS members revealed that 77% of those responding favored creation of an investigative body—separate from the Medical Examining Committee—empowered to suspend or revoke the licenses of physicians guilty of incompetency or serious misconduct.

ISMS currently is developing legislation which, if enacted, would create a statewide monitoring system to curb prescribing abuses and other illegal and unethical practices. The system possibly would call upon R&E's Bureau of Drug Compliance and also the Illinois Department of Law Enforcement to investigate all complaints. These agencies could, when necessary, request that physicians review questionable situations.

The success of any disciplinary system is dependent partially upon the cooperation it receives from practicing physicians. Regardless of the outcome of our legislative efforts and the shortcomings of the present state system, each of us has a moral and ethical responsibility to insure that unscrupulous physicians are not al-

lowed to practice. Each of us has an obligation to report these individuals to R&E and to our ethical relations committees.

Medicine's peer review activities are commendable. However, peer review becomes little more than a hollow mockery if it is not effective.

Each of us has taken a solemn oath that he or she will ". . . abstain from whatever is deleterious and mischievous . . . and will abstain from every voluntary act of mischief or corruption. . . ." Certainly it is not in the best interest of the public, our patients *or our profession* to shut our eyes to unethical or illegal conduct.

If we remain silent and fail to act, we lend credibility to the charges of our critics.

We do, indeed, become conspirators.

William E. Scrivner M.D.

Unity + Strength = Effectiveness

To all ISMS and Auxiliary members and their families, we extend our best wishes for the New Year, and our hopes that 1974 will bring continued growth in the unity and strength needed to effectively meet the challenges facing the medical profession.

Ruth and Willard Scrivner

President Scrivner On Tour



Dr. Scrivner addresses meeting of Lake County Medical Society in Waukegan.



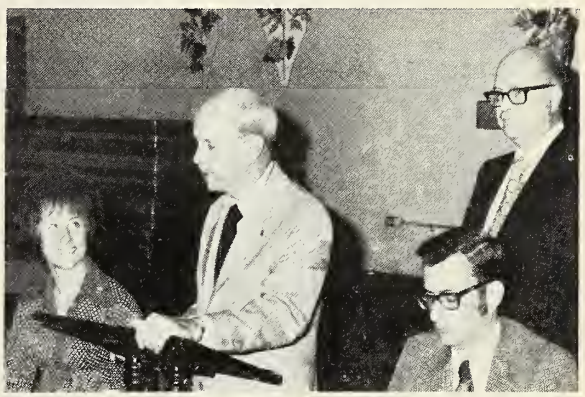
Dr. Scrivner with Lionel Ganshirt, M.D., President-Elect of Lake County Medical Society, during dinner meeting in Waukegan.



Dr. Scrivner being interviewed by *Champaign Courier* reporter Wayne Heuring — whom he delivered 26 years ago.



Dr. Scrivner addresses 8th District meeting in Champaign. From left, Roger N. White, ISMS Executive Administrator; Dr. Scrivner; Harold J. Kolb, M.D., President, Champaign County Medical Society, and Eugene Johnson, M.D., ISMS 8th District Trustee.



Willard C. Scrivner, M.D., speaks before Moline workshop for members of American Assoc. of Medical Assistants, Illinois Chapter. At left is chapter President Norma Domanic, New Lenox; Standing at right is William Kleinschmidt, M.D., President of Rock Island Medical Society. Seated at right is James Thiele, Director of Audits for CHAMPUS.



Dr. Scrivner during press conference in Champaign, where he addressed Champaign County Medical Society.



Dr. Scrivner chats with Theodore Grevas, M.D., Rock Island, during dinner meeting of Rock Island County Medical Society. Dr. Grevas is an ISMS delgate to the AMA.

The Weight of Professional Opinion

It's time for action to defend the laws and regulations that protect your patients against drug substitution.

These professional and trade organizations are united in supporting antisubstitution statutes and regulations

The American Academy of Dermatolo

The Board of Directors of the American Academy of Family Physicians

The Executive Board of the American Academy of Neurology

The Committee on Drugs of the American Academy of Pediatrics

The American College of Allergists

The Executive Committee of the American College of Obstetricians and Gynecologists

The Board of Regents of the American College of Physicians

The Board of Trustees of the American Dental Association

The Board of Trustees of the American Medical Association

The American Psychiatric Associat

The Executive Committee of the National Association of Retail Druggists

The Board of Directors of the Pharmaceutical Manufacturers Association

The National Wholesale Druggists' Association



Editorials



Socialized Law

Dr. F. J. L. Blasingame, writing in his "Medical News Reports," indulges in some interesting hypotheses relative to legal fees. "Suppose the President, the Vice President, or the Speaker of the House had something terrible happen to him, like being caught in a fire and being critically burned. Suppose after many months and numerous skin grafts and the services of a team of medical specialists, he recovered . . . and the total bill for saving his life was half a million dollars."

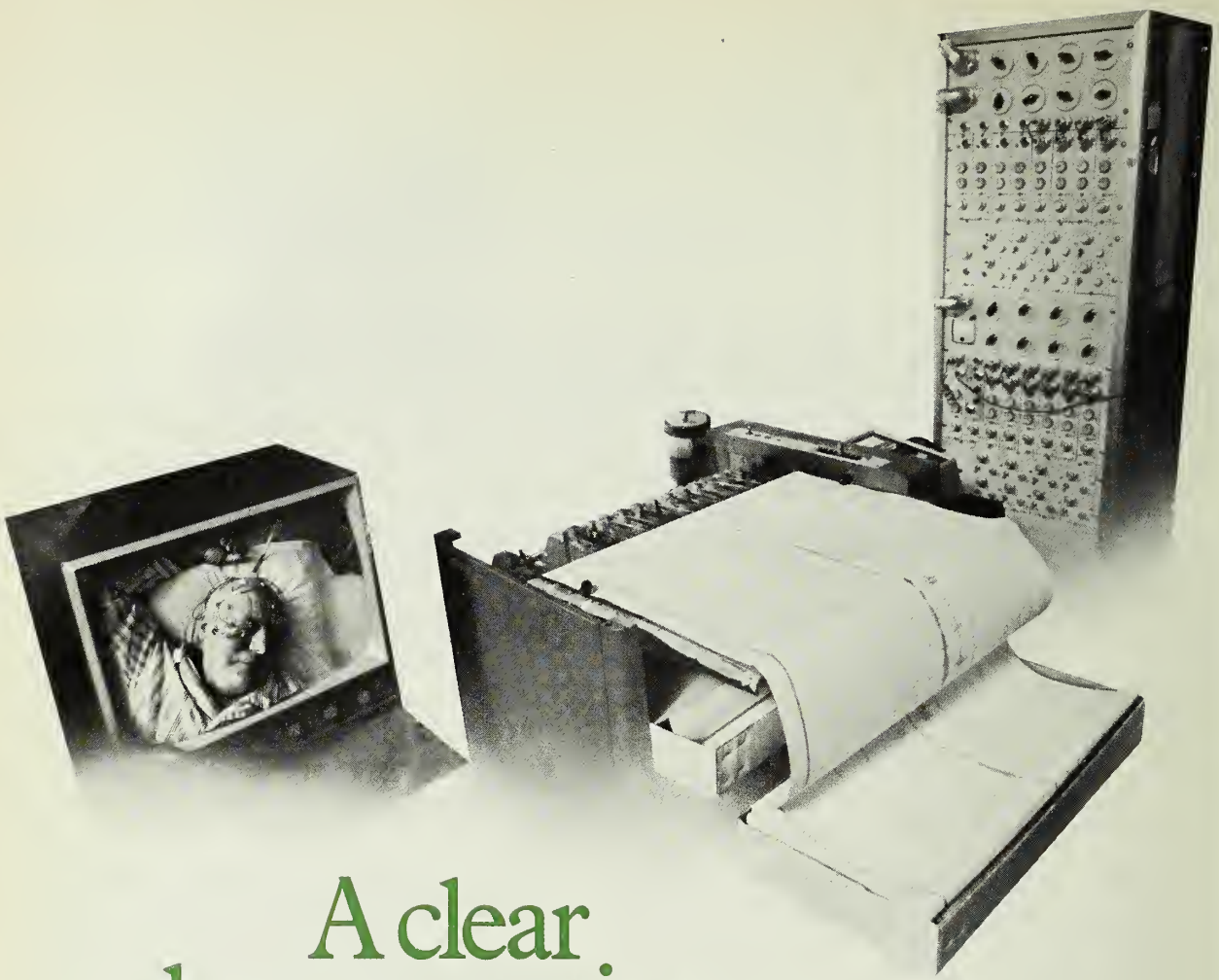
Blasingame is sure that the bleeding heart liberals would pick up the cudgel and start another campaign against the high cost of medical care which, in turn, might precipitate "a new liberal crusade to save Americans from venal physicians by nationalizing medicine." This was written before our Vice President resigned, but many physicians will recall that early in October friends of Spiro Agnew announced that a committee had been formed to raise half a million dollars to finance Agnew's defense against charges of accepting bribes and other wrongdoings while he served as Governor of Maryland.

None of the chief advocates of socialized medicine, including Senator Ted Kennedy and United Auto Worker's President Leonard Woodcock, said a word about the high cost ($500,000) of defending Agnew in the courts. Apparently, high legal fees are expected and even acceptable, when considering matters of justice. This is another example of how high legal fees deny the poor from receiving equal justice in the courts. According to Blasingame, few low income persons can afford to pursue a claim for damages against a corporation or another individual, even if all the facts are in their favor. The cost of any long, tedious court process is almost prohibitive.

On the other hand, a rich person can hire the ablest man to defend him against a crime and spend as much time as necessary to have this done. A poor man might be able to get a lawyer on a contingent fee basis, but usually must take one assigned by the court.

Most of the half million dollars earmarked for Agnew's defense would have been paid to lawyers. Court costs are nominal compared to fees charged by attorneys. Judges, clerks, and other court employees are supported by taxes: we agree with Blasingame that a program should be started to nationalize the legal profession so the poor can afford justice. If government control of medicine is needed, why not government control of lawyers with the Senate and the House determining their usual and customary scale of fees? This would be impossible because most elected officials are lawyers who make laws that are to be broken so that other barristers can defend the culprit and be rewarded handsomely.

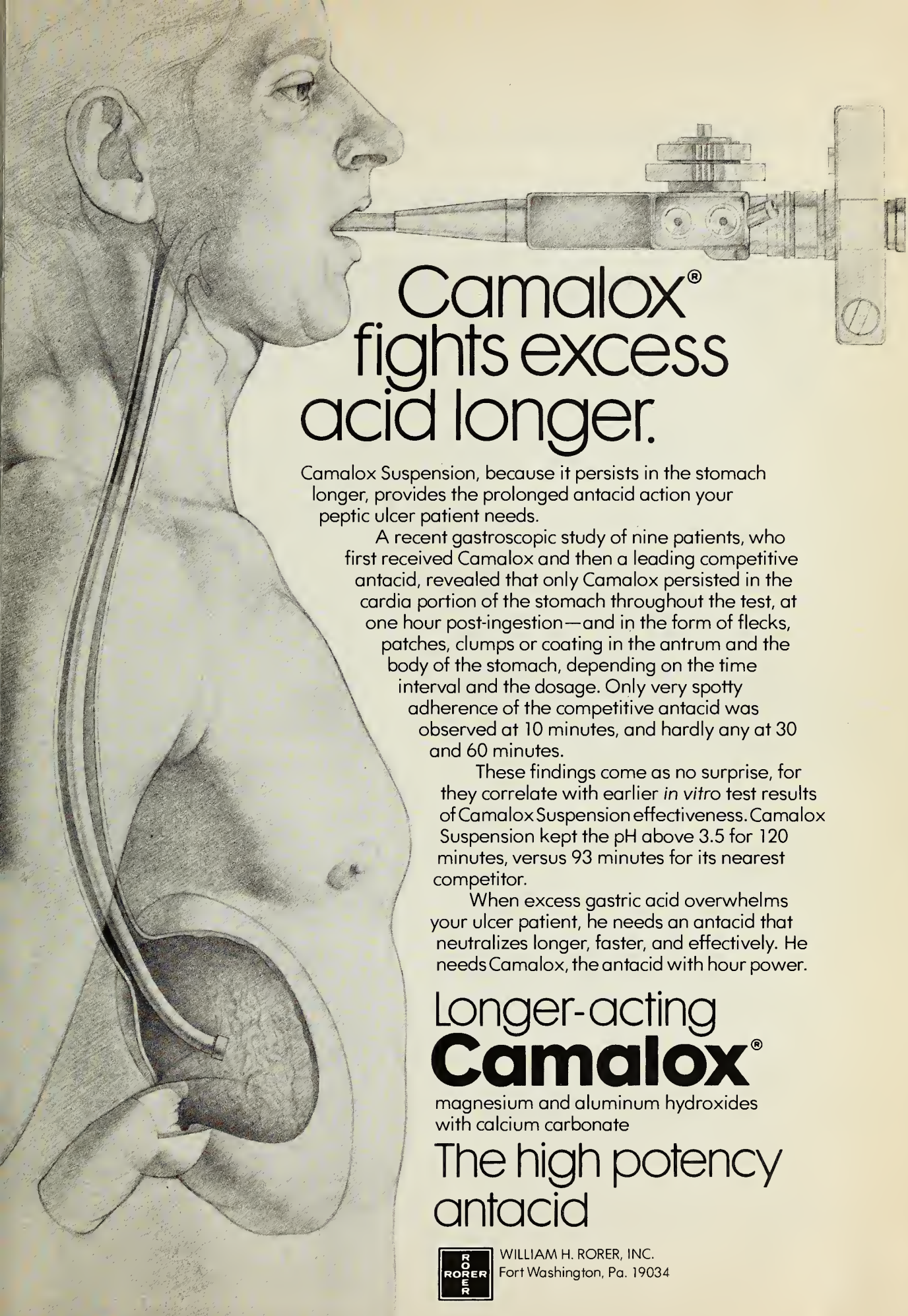
T. R. Van Dellen, M.D.
Editor



A clear demonstration of Dalmane® (flurazepam HCl) effectiveness.

Sleep research laboratory clinical evaluations have repeatedly demonstrated the consistent effectiveness of Dalmane (flurazepam HCl).[1-9]

In a series of three double-blind trials, each assessing the effectiveness of a different sleep agent (chloral hydrate 1000 mg, glutethimide 500 mg and Dalmane 30 mg) it was reported[3] that only Dalmane induced and maintained sleep throughout a two-week period of use. Although chloral hydrate and glutethimide were effective in inducing and maintaining sleep initially, a significant reduction of effectiveness developed in one or more parameters by the end of the administration period. By contrast a single 30-mg capsule of Dalmane continued to provide a favorable sleep response in all patients studied.



Camalox® fights excess acid longer.

Camalox Suspension, because it persists in the stomach longer, provides the prolonged antacid action your peptic ulcer patient needs.

A recent gastroscopic study of nine patients, who first received Camalox and then a leading competitive antacid, revealed that only Camalox persisted in the cardia portion of the stomach throughout the test, at one hour post-ingestion—and in the form of flecks, patches, clumps or coating in the antrum and the body of the stomach, depending on the time interval and the dosage. Only very spotty adherence of the competitive antacid was observed at 10 minutes, and hardly any at 30 and 60 minutes.

These findings come as no surprise, for they correlate with earlier *in vitro* test results of Camalox Suspension effectiveness. Camalox Suspension kept the pH above 3.5 for 120 minutes, versus 93 minutes for its nearest competitor.

When excess gastric acid overwhelms your ulcer patient, he needs an antacid that neutralizes longer, faster, and effectively. He needs Camalox, the antacid with hour power.

Longer-acting **Camalox®**

magnesium and aluminum hydroxides with calcium carbonate

The high potency antacid

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

Clinics for Crippled Children Listed for February

Twenty-eight clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 20 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

February 5 Belleville—St. Elizabeth's Hospital
February 6 Carlinville—Carlinville Area Hospital
February 6 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
February 6 Hinsdale—Hinsdale Sanitarium
February 7 Sterling—Sterling Community Hospital
February 7 Flora—Clay County Hospital
February 7 Anna—Union County Hospital
February 7 Lake County Cardiac—Victory Memorial
February 8 Chicago Heights Cardiac—East Chicago Heights Community Center, Inc.
February 11 Peoria Cardiac—St. Francis Children's
February 12 Peoria—St. Francis Children's
February 13 Champaign-Urbana — McKinley Hospital
February 14 Springfield—St. John's Hospital
February 14 Kankakee—St. Mary's Hospital
February 19 East St. Louis—Christian Welfare
February 19 Rock Island—Moline Public Hospital
February 20 Springfield Pediatric Neurology—Diocesan Center
February 20 Chicago Heights—East Chicago Heights Community Center, Inc.
February 21 Rockford—St. Anthony Hospital
February 21 Bloomington—Mennonite Hospital
February 21 DuQuoin—First Methodist Church
February 21 Elmhurst Cardiac—Memorial Hospital of DuPage County
February 22 Evanston—St. Francis Hospital
February 22 Chicago Heights Cardiac—East Chicago Heights Community Center, Inc.
February 25 Peoria Cardiac—St. Francis Children's
February 26 Peoria—St. Francis Children's
February 26 Danville—Lake View Hospital
February 27 Aurora—St. Joseph Mercy Hospital

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.

WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

PR-GP-31-B/W

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND
BALTIMORE

IMJ
Illinois Medical Journal

Vol. 145, No. 1, January, 1974

Probable 16 Year Course in A Patient With Thrombotic Thrombocytopenic Purpura

By Dee C. Boswell, M.D. and Gregorio Sierra, M.D./Centralia

Thrombotic thrombocytopenic purpura is generally considered a rapidly fatal illness terminating within a few weeks or months.[1,2] Today numerous cases are being recognized with a more prolonged course. This paper describes a patient whose initial illness 16 years earlier resembled the terminal episode which was clinically recognized as thrombotic thrombocytopenic purpura.

Case Report

A 57-year-old Caucasian woman entered the hospital on August 17, 1970, with purpura. She died on August 31, 1970, of thrombotic thrombocytopenic purpura.

In 1954 the patient entered the hospital with severe anemia and purpura on her extremities. She had received an injection of penicillin three weeks prior to admission for diffuse myalgias, abdominal pain and weakness believed to have been caused by the "flu." Except for weakness, purpura and pale mucus membranes, the physical examination was unremarkable. Values from laboratory examinations were as follows: red blood cell count 2.18 million per mm^3; hemoglobin concentration 40% of normal; white blood cell count 6,600 per mm^3; 72% polymorphonuclear leukocytes, 28% lymphocytes; platelet count 100,000 per mm^3; Kahn test negative.

The authors are on staff at St. Mary's Hospital, Centralia; DEE C. BOSWELL, M.D., is from the Department of Internal Medicine and GREGORIO SIERRA, M.D., is from the Department of Pathology.

A stool examination for occult blood was negative. Hematuria or proteinuria was not recorded.

The patient's hospital course was stormy with intermittent chills, fever to 101 degrees F. rectally, mental torpor and confusion, headaches, weakness, nausea and vomiting, paresthesiae, urinary incontinence and pains in her chest and abdomen. During the course of her illness she received 3,000 ml of whole blood. She was discharged well on the 54th day.

The patient remained well until 1967 when she was admitted to the hospital with marked anemia and purpura. She had received an injection of penicillin one week prior to admission to the hospital for an "infection" in her ovary. Except for the purpura and pale mucus membranes the physical examination was unremarkable. Values from laboratory examinations were as follows: hematocrit 20%; hemoglobin 7.0 grams%; white blood cell count 16,000 per mm^3; 68% polymorphonuclear leukocytes, 26% lymphocytes, 6% monocytes; platelet count 108,000 per mm^3. The blood smear revealed two

nucleated red blood cells per 100 white blood cells counted.

The hospital course included intermittent chills, fever to 100 degrees F. rectally, nausea, headache, apprehension and weakness. She received 2,000 ml of whole blood. She was discharged well on the 14th day.

Four months later the patient underwent uneventful left salpingo-oophorectomy for "chronic salpingitis and endometriosis." A complete blood count prior to surgery was normal.

The patient entered the hospital for the final time on August 17, 1970, because of purpura on her legs and trunk of three days duration. She had received a brief course of oral neomycin three weeks prior to admission to the hospital for bilateral lower abdominal pain believed to be due to diverticulitis. Physical examination revealed purpura on her thighs and petechiae on her trunk and extremities. The mucus membranes were pale. There was no scleral icterus. The liver, spleen and lymph nodes were not palpable. Pulse 84 per minute and regular. Blood pressure 120/80 mm of mercury. Oral temperature 98.6 degrees F. Remainder of the physical examination was unremarkable. Values from laboratory examinations were as follows: hematocrit 27%; hemoglobin 9.7 grams %; white blood cell count 5,100 per mm^3; 78% plymorphonuclear leukocytes, 22% lymphocytes; platelet count 8,000 per mm^3. A Lee-White clotting time was 10 minutes. The bleeding time was 22 minutes. A peripheral blood smear revealed reduced platelets but no other abnormalities. A sternal bone marrow was "hypocellular." Adequate numbers of megakaryocytes were seen in the marrow.

During the first week of hospitalization the patient complained of "weak spells," fatigue and mild diarrhea. The cause of her illness during this week remained obscure. Because of the hypocellular bone marrow, the anemia and thrombocytopenia, she was started on Prednisone 40 milligrams per day orally, fluoxymestrone 40 milligrams per day orally and was transfused with 500 ml of packed red blood cells. The second hospital week began with an abrupt onset of coma, incontinence of stool, rectal temperature to 100 degrees F. and gross hematuria. Laboratory examinations revealed the following: blood urea nitrogen 30 milligram %; prothrombin activity 71%; direct reacting bilirubin .6 milligrams %; indirect reacting bilirubin 3.2 milligrams %; lactic acid dehydrogenase activity 5,040 Sigma units. A peripheral blood smear

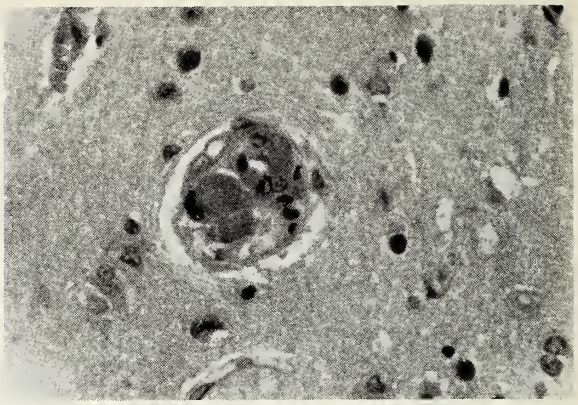


Figure 1. Microscopic section of the brain with a typical hyaline microthrombus (hematoxylin and eosin).

revealed numerous schistocytes, markedly reduced platelets and 13 nucleated red blood cells per 100 white blood cells counted. A serum immunoelectrophoresis was normal. The following tests were negative: three blood cultures, VDRL, lupus erythematosus preparations, antinuclear antibodies, direct and indirect Coomb's tests.

On the eighth hospital day it was believed that the patient had thrombotic thrombocytopenic purpura and she was begun on intravenous hydrocortisone 2 grams per day, heparin 3,000 units intravenously every 6 hours and multiple whole blood transfusions were given. Massive hemorrhage into the right thigh after the second dose of heparin precluded further heparin administration. During the final six days of her life she remained in coma with nearly continuous generalized seizures which became impossible to control. She remained febrile with rectal temperature to 102.8 degrees F. Generalized bleeding occurred with persistent gross hematuria, bloody diarrhea, epistaxis and hemoptysis. Cephalothin intravenously 6 grams per day and kanamycin intravenously 1 gram per day were instituted because of the appearance of a left lower lobe infiltrate on chest X-ray 24 hours prior to the patient's death.

Autopsy revealed gross petechiae throughout the entire cerebral cortex and midbrain. Hemorrhagic pneumonia was present in both lungs. Microscopic sections revealed hyaline microthrombi in the glomeruli of the kidney, and in the pancreas, pituitary gland, adrenal gland, brain, lung, spleen, heart and throughout the gastrointestinal tract. (Figure 1)

Comments

Prolonged survival in thrombotic thrombo-

cytopenic purpura is well known. In a review of 271 cases by Amorosi and Ultmann 15 patients survived more than one year.[2] One patient lived 16 years after the initial episode.

Whether our patient's illness in 1954 was thrombotic thrombocytopenic purpura is unknown; however, several features suggest this diagnosis. Four of the five classical features of thrombotic thrombocytopenic purpura were present, namely, thrombocytopenic purpura, anemia, fever and neurologic manifestations. Renal abnormalities were not described.

The patient's illness in 1967 was reminiscent of the episode in 1954, characterized by thrombocytopenic purpura, anemia, fever and neurologic symptoms.

Although the diagnosis of thrombotic thrombocytopenic purpura was not established until our patient's fatal illness, it is believed that she had the disease 16 years earlier. Her initial illness was followed by a 13 year remission, a brief relapse and a second remission of three years before her final episode of thrombotic thrombocytopenic purpura.

Clinically there are no distinguishing features between those patients dying early in the course of this disorder and those who have prolonged remissions. Severe neurologic manifestations are characteristic of those patients dying of thrombotic thrombocytopenic purpura but death is not inevitable in this group.[1]

Each of the three episodes of thrombocytopenic purpura in our patient followed antibiotic therapy for symptoms suggestive of an infectious disease. Infections and drugs have been incriminated in the pathogenesis of thrombotic thrombocytopenic purpura.[2-6] Conclusive evidence relating the pathogenesis of this disorder to infectious agents or to therapeutic agents has not been reported.

Thrombocytopenic purpura, hemolytic anemia, fever and hematuria suggested the possibility of systemic lupus erythematosus in our patient. However, negative lupus cell preparations, antinuclear antibodies and a negative VDRL mitigated against this diagnosis. Common features in systemic lupus erythematosus and thrombotic thrombocytopenic purpura has been suggested as evidence that the latter may be an autoimmune disorder.[7]

The treatment of thrombotic thrombocytopenic purpura remains empiric. Since spontaneous remissions do occur, evaluation of response to therapy is difficult. Large doses of steroids clearly did not alter the course of the disease in our patient. Heparin therapy lead to serious hemorrhage. Splenectomy was considered unwarranted in our patient at the time of diagnosis because of her severe neurologic syndrome.

Whatever the initiating and perpetuating mechanisms may be in thrombotic thrombocytopenic purpura, it is likely that many cases are not recognized because of spontaneous recoveries. Recognition of this protein disorder in its mild forms may lead to further clues of its pathogenesis and a more rational approach to therapy.

Summary

A patient is presented who survived for sixteen years after an illness which is believed to have been thrombotic thrombocytopenic purpura. Her terminal illness fulfilled the classical criteria for diagnosis of this disorder: (1) anemia (2) thrombocytopenic purpura (3) fever (4) renal abnormalities and (5) neurologic abnormalities. Although renal abnormalities were not recorded during the initial episode, her course was highly suggestive of thrombotic thrombocytopenic purpura. Two prolonged remissions occurred. Survival for sixteen years after the onset of thrombotic thrombocytopenic purpura is thought to be one of the longest recorded. ◄

Acknowledgements

The authors are grateful to Dr. Harold Snow for kindly referring this patient. We are indebted to Dr. Virgil Loeb, Department of Hematology, Washington University School of Medicine, St. Louis, Mo., for his constructive criticisms and special thanks to Mrs. Anne Deley and Dr. Roger E. Burga for their assistance.

References

1. Cahalane, S. F., Horn, R. C.: "Thrombotic Thrombocytopenic Purpura of Long Duration." *Amer. J. Med.* 27:333-341, 1959.
2. Amorosi, E. L.: Ultmann, J. E.: "Thrombotic Thrombocytopenic Purpura: Report of 16 cases and Review of the Literature." *Medicine* 45:139-159, 1966.
3. Mettler, N. E.: "Isolation of a Microtatobiote From Patients With Hemolytic-uremic Syndrome and Thrombotic Thrombocytopenic Purpura and From Mites in the United States." *New Eng. J. Med.* 281:1023-1027, 1969.
4. Soumerai, S. MacGillivray, W. F.: "Thrombotic Thrombocytopenic Purpura: Report of a Case with a Review of the Pathogenesis of the Disease." *New Eng. J. Med.* 255:585-589, 1955.
5. Cohen, P. Gardner, F. H.: "Thrombocytopenia as a Laboratory Sign and Complication of Gram-negative Bacteremic Infection." *Arch. Intern. Med.* 117:113-124, 1966.
6. Gendel, B. R., Young, J. M., Kraus, A. P.: "Thrombotic Thrombocytopenic Purpura." *Amer. J. Med.* 13:3-11, 1952.
7. Norkin, S. A., Freedman, H. H., Evans, G. W.: "Thrombotic Thrombocytopenic Purpura in Siblings." *Amer. J. Med.* 43:294-303, 1967.

Failure of Corticosteroid in the Treatment of Duchenne (Pseudo-Hypertrophic) Muscular Dystrophy

Report of a Clinically Matched Three Year Double-Blind Study

By Irwin M. Siegel, M.D., Joseph E. Miller, M.D., and Robert D. Ray, M.D./Chicago

Duchenne muscular dystrophy is a primary myopathy of childhood, transmitted through a sex-linked recessive hereditary pattern and characterized by progressive weakness and disability which result in a downhill course terminating in cardio-respiratory death by middle to late adolsecence.[1] The primary pathology of this disease is unknown, and to date no treatment has yet been found to arrest its relentless course.

Triamcinolone steroid myopathy has been reported.[2-4] On the other hand, corticosteroids have been found effective in the treatment of the inflammatory myopathies.[5] During the early and middle 60's a number of papers, mainly in French or Italian, reported the use of corticosteroids in muscular dystrophy. Although these studies were negative in their findings, the usefullness of this medication in the treatment of the hereditary forms of the disease has never been adequately tested.

This report documents a three-year clinically matched double-blind evaluation of corticosteroid (prednisolone) in the treatment of Duchenne muscular dystrophy. We hope through its publication to prevent the inappropriate use of this drug in similar cases.

Method

Seven pairs of male patients with clinical and laboratory confirmed diagnosis of Duchenne muscular dystrophy were matched as closely as possible regarding (1) age, (2) height and weight, (3) clinical history, and (4) distribution and extent of weakness, contracture and disability.

A program of supportive and symptomatic care including adequate diet and exercise was carried out in each case. A baseline assessment of strength and range of motion of select muscle groups, as well as a comprehensive functional assessment (ability to perform and length of time taken to perform a series of standard functional tasks)[6] was performed on each subject prior to and at three-monthly intervals during the study. One patient of each matched pair was placed on Prednisolone (5 mg. per kg. body weight) administered as a total 48-hour dosage in a single dose every other day.[7] The other member of the pair was given a placebo, similarly administered.

Each child was seen and assessed every three months (more frequently where indicated) for a period of three years. Although specific elements of each evaluation varied from time to time and from patient to patient, a numerical grade, based on a comparative scale of 7 (see chart 1) was assigned at each assessment. To minimize error due to transient loss or gain of strength secondary to examiner's error, growth, etc., medication was administered for a period of two years. Key grading of each patient was made after one year of therapy, at the end of therapy, and one year after discontinuation of medication.

The identity of the drug each patient received was unknown to the investigators, the therapist assessing the patient, the patients themselves or

IRWIN M. SIEGEL, M.D., is a Clinical Associate Professar, Department af Orthapaedic Surgery at the University af Illinais, College af Medicine, Chicago and staff arthapaedic surgean at Strauss Surgical Graup Assaciatian, S.C., Lauis A. Weiss Memarial Haspital, Chicaga. JOSEPH E. MILLER, M.D., is Professar and Chief af the Department af Orthapaedic Surgery at Mantreal General Haspital, Montreal, Quebec, Canada. ROBERT D. RAY, M.D., is Professor and Chairman af the Department af Orthopaedic Surgery at the University af Illinois College af Medicine, Chicaga.

Chart 1
EVALUATION

GRADE

(1) Dramatic Improvement—Very striking improvement in measurable strength or function.
(2) Moderate Improvement—Quite clear decrease in time to accomplish any functional test, or quite clear improvement in strength consisting of improvement of at least one grade by manual muscle testing, or at least 30° movement against gravity.
(3) Slight Improvement—Clear but minimal improvement in either strength or function.
(4) No Change.
(5) Slight Loss of Strength—Minimal but quite clear loss of strength or increase in time required to complete one function at least.
(6) Moderate Loss of Strength—Obvious loss of strength at several levels and quite significant loss of functional ability, such as change of method in one or two functions.
(7) Marked Loss of Strength—Dramatic change in strength or function such as inability to walk without braces.

their families. At the conclusion of the study the drug key was broken and each subject identified as having received the active medication or placebo.

Results (Chart 2)

Although the extent of weakness and disability varied between matched patient pairs, every child was able to ambulate independently, handle his tasks of daily living with minimal aid, and attend a regular school prior to inclusion in the study. There were no contractures severe enough to warrant surgical release and none of the subjects was braced.

Slight improvement was noted in one patient on corticosteroid at one year (2A) whose disability increased after another year of treatment. Another patient (3A) showed a loss of strength after one year of medication with a subsequent improvement after two years on the drug. (See chart 2)

Although a less rapid progression of the disease was noted in certain patients on corticosteroid (2A, 4A, 5A, 6A, 7A), and even after two years of medication (2A, 3A, 5A, 6A, 7A), the slight difference in grading between active and placebo members of each pair was not regarded as significant enough to represent a positive therapeutic effect of the drug.

In only one instance (3A) was improvement noted. In all other cases it appeared that the disease was only progressing less rapidly.

Ultimately, all patients were severaly disabled, seven of them requiring surgery (tenotomy) and bracing.[8,9]

Discussion

Almost all subjects on corticosteroids eventually showed mild Cushing-like features. Moon faces, slight weight gain, modest elevation of blood pressure were noted but easily controlled by low salt diet, natural potassium, and the other usual cautionary measures. No serious side effects secondary to the use of steroids were encountered, nor was it difficult weaning these patients from their medication after termination of the study. The use of alternate day dosage schedules is credited with the ease of administration of this medication.

Although transient and minimal slowing of the disease process was noted in several patients, as evidenced by lack of progression of weakness and disability, all subjects ultimately ended in the 5-7 category. It is postulated that those of each pair on active steroids who declined less rapidly and were graded with more strength at the end of the study were either expressing the normal increase of growth and maturation which, occasionally occurring in Duchenne dystrophic patients, exceeds the rate of progression of the disease for a time giving the appearance of improvement or a nonspecific effect of the medication.

Conclusion

Unfortunately, the cause and cure of Duchenne (pseudohypertrophic) muscular dystrophy remain undiscovered. Although Prednisolone may

(Continued on page 36)

Chart 2

Patient	Age** (yrs.)	GRADING			Required Lower Extremity Tenotomy and Bracing
		One Year On Medication	Two Years On Medication	One Year Off Medication	
1A*	8	4	5	6	
1P†	8	4	4	5	
2A	8	3	6	6	
2P	8	7	7	7	
3A	9	5	3	5	
3P	9	4	5	6	
4A	6	6	7	7	X
4P	6	7	7	7	X
5A	7	4	6	7	X
5P	7	7	7	7	X
6A	6	4	5	7	X
6P	6	7	7	7	
7A	7	5	6	7	X
7P	7	6	7	7	X

**Active medication; †Placebo; **At initiation of study*

A Perspective of Peripheral Health Care

By B. D. Reeves, M.D., S McCue, M.D., A. Wagner, Jr., M.D., and
T. W. McElin, M.D., M.S./Chicago and Evanston

Many of us in medicine are aware, and painfully so, of the debate, both from within and from without, concerning the "health-care system." There are multiple examples of this discussion[1-8] and, additionally, analyses, reviews and comments.[9-11] One cryptic observer has called it a cacophony—a dissonant, harsh, jarring sound. While it is not our desire to add unduly to the noise, we would like to share a perspective relating to maternal and fetal well being, which is a common point of reference in many of the broader discussions.

Our perspective has developed upon a comparison between two hospitals and women delivered in those hospitals during the first four months of 1971. Both hospitals are private, non-profit institutions, affiliated with medical schools with accredited residency programs. All staff have faculty appointments and are board-certified. Their facilities, while not identical, are very similar. In one hospital, Rush-Presbyterian-St. Luke's (RPSL), there are 3000 plus deliveries per annum, two thirds of which are "clinic" patients who live in the contiguous inner-city environments. In the other hospital, the Evanston Hospital (EH), there are 2000 plus deliveries per annum with a 10% "clinic" population. All of the Evanston Hospital patients dwell in the surrounding environment.

Because of the comparability of the two institutions, their staffs and facilities, we felt it would be informative to review some of the non-obstetric problems with which the obstetrical patient presented and to review the perinatal mortality for this four month period in the two populations.

Factors Reviewed

There were 519 random "clinic" deliveries at Rush-Presbyterian-St. Luke's and all 586 deliveries at Evanston Hospital from January 1 to April 30, 1971 as reviewed. (See Tables 1-5).

The authors are from the Department of Obstetrics and Gynecology, Rush-Presbyterian-St. Luke's Medical Center, Chicago, Northwestern University Medical School and Evanston Hospital, Evanston.

TABLE 1
AGE GROUPS

YEARS	RPSL	EH
10 to 15	51	4
16 to 20	202	68
21 to 35	238	483
36 to 40	20	26
Over 40	8	5

Table 1 shows a comparison between the two groups according to age.

Table 2 lists the significant diseases with which the women were afflicted prior to their current pregnancies.

Table 3 lists the significant problems associated with the current pregnancy, which probably were unrelated to pregnancy.

TABLE 2
PREVIOUS DISEASE

CONDITION	RPSL	EH
Eclampsia	2	0
Pre-Eclampsia	26	0
Hypertension	13	2
Urinary Tract Disease	41	11
Diabetes	5	2
Heart Disease	9	0
Pulmonary Disease	11	3
Hyperthyroidism	1	1
Hypothyroidism	0	3
Tuberculosis	5	2
Cancer	1	0

TABLE 3

CURRENT DISEASE

CONDITION	RPSL	EH
Pre-Eclampsia and/or Hypertension	74	35
Urinary Tract Disease	19	24
Gonorrhea	18	1
Syphilis	4	0
Pulmonary Disease	6	2
Heart Disease	3	0
Carcinoma In-Situ	2	1
Hyperthyroidism	1	0
Psychiatric Disease	3	0
Narcotic Addiction	2	0
Diabetes	16	7
Epilepsy	2	0

TABLE 4

ANTEPARTUM ANEMIAS

HGB. GM%	RPSL	EH
6-6.9	1	0
7-7.9	1	0
8-8.9	13	2
9-9.9	32	7
10-10.9	101	37
	148 (29%)	46 (8%)

TABLE 5

GROSS PERINATAL MORTALITY RATE

(Per 1000 live births)

	RPSL	EH
CLINIC	30.2	15.6
TOTAL	27.8	13.2

Table 4 indicates the level of hemoglobin (in grams per 100 ml) of all patients whose hemoglobin determination was less than 11 grams % at the time of their initial prenatal visits.

Table 5 gives the total gross perinatal mortality rate for each of the two institutions for the clinic patients and total patients.

Review of these data indicates that a multiplicity of factors contributory to "high-risk" pregnancy exist to a much greater extent in the inner-city hospital clientele as opposed to the suburban patients. Chief among those factors more frequent in the inner-city groups are the following: teenage pregnancy is approximately three and one-half times as frequent: toxemia in prior pregnancy was vastly more frequent; hypertension, urinary tract, pulmonary and heart disease in a prior pregnancy were significantly more frequent. Additionally, in the current pregnancy, toxemia, hypertension and diabetes were more frequent in the RPSL population by a factor of 2:1, and it is observed that there was only a single instance of venereal disease in the EH series as opposed to 28 instances in the inner-city series. Most significantly, antepartum anemia was four times more frequent in the disadvantaged patient. In view of this marked differential and despite the high and equal caliber of health care facilities and personnel, it is little wonder that the gross perinatal morbidity was doubled in the RPSL setting.

These data, it seems to us, in a small but significant way add credence to a position held by several analysts of the general health-care scene[3,5,9,12,13] while reinforcing and reiterating the particular effects upon the maternal, fetal and newborn well-being so well articulated by Hendricks.[14]

That position is that medical programs are, to a very large extent, peripheral or marginal to the people's health and welfare; more germane and central is the quality of life—to socioeconomic status, the education, the mores and the sense of dignity and self-respect. As indicated by Cook,[12] the only real prospect for improving medical care is to deal with the problem in the larger context of social and other economic ills unrelated to provision of health care.

At the same time, we would not mean to imply that this is a simple solution or the total solution to the current health-care delivery problem. The pitfalls of such a simplistic approach are becoming more and more apparent as our world becomes more complex.[15] We do not mean to imply that certain changes in medical care programs are not indicated. Certainly, review and revision are necessary in the sense of pursuing the principles of excellence and self-renewal so well articulated by Gardner.[16]

We do agree, however, with Dr. Mark S. Blumberg[17], Corporate Planning Advisor of the Kaiser Foundation Health Plan, who warns, "—against the assumption that more health services will improve health." "There is no correlation between a nation's general level of health care and the number of doctors per capita. I am convinced that among the developed countries, most of the international differences are not due to health care providers or health care systems—they are due to radical differences in socioeconomic standards." As succinctly summarized by

Gladston in *Medicine in Transition,*[18] "To project future developments in medical education and in medical services along the pattern of the past is to ignore or to misread the lessons of present." And, "Medicine should envisage its own destinies in the perspective of the larger social dynamics."

Summary

A comparison was made between women delivered during the first four months of 1971 at the Rush-Presbyterian-St. Luke's Medical Center in the inner-city of Chicago and at Evanston Hospital in suburban Evanston. While there are some differences, the institutions are comparable in many ways. The populations compared obviously represented the populations geographically related to the hospitals. There were 519 patients in the Rush-Presbyterian-St. Luke's group and 586 patients in the Evanston Hospital group. A comparison was made of age group distribution, previous illness, current pregnancy illness, and perinatal mortality. These data support the contention of several analysts who maintain that health-care systems are peripheral to the health of the society and that the central, germane aspects of health are socioeconomic. ◄

References

1. Valentine, W. N., "The Not-So-Distant Drums", Presidential Address, Western Association of Physicians, January 28, 1970.
2. Ludwig, E. G., and Collett, J. C., *JAMA,* 216:493, April 19, 1971.
3. Biorck, G., *Modern Medicine,* August 9, 1971.
4. Carnegie Report, *Higher Education and the Nation's Health,* McGraw-Hill, New York, 1970.
5. Ginsberg, E., and Ostraw, M., Men Money and Medicine, Columbia University Press, New York, 1969.
6. Greenberg, S., *The Quality Of Mercy,* Atheneum, New York, 1971.
7. Gerber, A., *The Gerber Report,* McKay, New York, 1971.
8. Ehrenreich, J., and Ehrenreich, B., The American Health Empire, Random House, New York, 1970.
9. Mechanic, D., Science, 168:1563, June 26, 1970; 172: 701, May 14, 1971.
10. Edelson, E., Chicago Tribune World Book, V (4):1, January 24, 1971.
11. Lear, J., *Saturday Review,* pp. 33-47, April 17, 1971.
12. Cook, J., *OB-GYN News,* April 1, 1971.
13. Monroe, K. E., "Reference Data on Socioeconomic Issues of Health, *JAMA,* 1971.
14. Hendricks, C. H., *Am. J. Obstet. Gynecol.* 97:608, 1967.
15. Forrester, J. W., World Dynamics, Wright-Allen Press, Boston, 1971.
16. Gardner, J. W., Excellence, 1961 and Self-Renewal, 1964, Harper and Row, New York.
17. Blumberg, M. S., *AMA Newsletter,* April 1, 1971.
18. Gladston, I., Medicine In Transition, University of Chicago Press, Chicago, 1965.

Corticosteroid Failure in Treatment of Duchenne Muscular Dystrophy

(Continued from page 33)

prove of transient and nonspecific benefit in a few cases of this disease, it has no ultimate therapeutic value. ◄

Acknowledgment

The authors wish to acknowledge the valuable help of Miss Janet L. Bauch, R.P.T., Miss Gail Johnson, R.P.T., Miss Wendy Linzer, R.P.T., and Miss Julie A. Solomon, R.P.T. for their skill and patience in evaluating the children in this study.

References

1. Zundel, W. S. and Tyler, F. H. "The Muscular Dystrophies." *N. Eng. J. Med.* 269:591-596, 1963.
2. Perkoff, G. T., Silber, R., Tyler, F. H., Cartwright, G. E., and Wintrobe, M. M. "Studies in Disorders of Muscle. XII. Myopathy Due to the Administration of Therapeutic Amounts of 17-Hydroxycortico-Steroids." *Am. J. Med.* 77:891-898, 1959.
3. Williams, R. S. "Triamcinolone Myopathy." *Lancet* 1:698-701, 1959.
4. Hagstrom, J. W. C., Roseman, D. M., and Ellis, J. T. "Debilitating Muscular Weakness and Steroid Therapy." *Arch. Neurol.* 5:60-67, 1961.
5. Thompson, C. "Polymyositis in Children." *Clin. Pediat.* 7:24-28, 1968.
6. Miller, J. E. "Assessment in the Treatment of Muscle Disease (Preliminary Report)." *Texas Rep. Biol. & Med.* Suppl. 22, No. 1, 871-879, 1964.
7. Harter, J. G., Ready, W. J., and Thorne, G. W. "Studies on an Intermittent Corticosteroid Dosage Regimen." *N. Eng. J. Med.* 269:591-596, 1963.
8. Siegel, I. M., Miller, J. E., and Ray, R. D. "Subcutaneous Lower Limb Tenotomy in the Treatment of Pseudohypertrophic Muscular Dystrophy." *J. Bone and Joint Surg.* 50-A:1437-1443, 1968.
9. Spencer, G. E., Jr. and Vignos, P. J., Jr. "Bracing for Ambulation in Childhood Progressive Muscular Dystrophy. *J. Bone and Joint Surg.* 44-A:234-242, 1962.

Curling

The Psychological Value of the Sport

By Thomas N. Davis, III, M.D./Waukegan

Massachusetts Physician (April, 1972) published an editorial on curling, "For Arteries and Fun," which described the rudiments of the game and then recommended curling as a good conditioning game which can be played all through the winter season, a game which can restore a satisfactory blood flow through constricting arteries. It said that one of the pleasant aspects of curling is that the novice gets as much pleasure as the expert. It is a game whose fundamentals are easily learned, though its strategy may take years. With tongue in check, the editorial concluded, "One of the dangers of the game is the possibility, even the probability, of becoming an addict, but the addict will be a healthy one."

The importance of regular physical activity for health has become increasingly apparent in recent years owing to the leadership of Paul Dudley White and other physicians and medical scientists. Curling provides good winter exercise, as I have reportedly previously in the *Journal of the Indiana State Medical Association* (Dec., 1967). Here I wish to review briefly how curling is played and then give its psychological value.

How The Game Is Played

Curling is played on a sheet of ice about 140 feet long. Not skaes, but rubber soled shoes are worn. It is somewhat like shuffleboard but is a much more demanding sport. Standardized round granite stones with goose neck handles are used. They resemble kettles in shape and they weigh 42½ pounds. Curling is always played as a team game with four players per team. Each player delivers or slides two stones per "end" (inning). The game starts with one team's first player delivering his first stone from the "hack" at one end of the ice. He does this according to the directions of his "skip" (captain), who stands at the other end, the target end, of the ice. The other two teammates stand at the side with brooms ready to sweep vigorously the pathway of the stone according to the skip's directions. The sweeping, which must be forceful to be effective, is done for one or both of two reasons. It can make the stone go as much as 15 additional feet. (In theory, at least, the sweeping is done forcefully enough to melt the surface of the ice.) Sweeping also delays the curving motion of a stone, which, as it loses momentum, tends to swing to one side as much as several feet. (The name curling comes from this curving motion.) Control of both the stone's distance and direction is essential.

The target is the center of a circle 12 feet in diameter painted on the ice. The object is—as in horseshoes—to get closer to it than your opponents' best. One team only can score at a time. They can score as many as eight points per end, but this is rarer than a golfer's "hole in one."

After the first stone is played, the other team plays its first stone. Thus the stones are played alternately until all 16 have been played. The score for that end is determined. Then the next end is begun, the direction of play being reversed. A game usually consists of 10 ends and takes about two hours to play.

With as little as an half hour of instruction a novice can play satisfactorily as "lead" or first player on a team. But it takes many years to develop the skills needed to be a "skip," the captain and last one of the team to play. A skip should not only be a good shotmaker, but he needs to know strategy. He must be able to "read" the ice, which is never perfect and varies frequently in "speed" and levelness. He should be aware of the skills and shortcomings of all eight players.

Getting a stone near the target is comparatively easy. But keeping it there against skilled opponents is something else. For forceful "take-

THOMAS N. DAVIS, III, M.D., Waukegan, maintoins a private practice in psychiatry and is associoted with the Mental Health Clinic far McHenry County and the Stickney Tawnship Mental Health Center. Dr. Davis is a Past President of the American Medical Curling Associatian.

out" shots are part of the armamentarium of a good player. A well placed stone can be knocked away. There are a variety of shots and of strategy. There are simple "draws" which curve to the right or left before coming to rest. There are take-outs. There are guards, which are stones positioned in front to protect others. And, there are "wicks," which carom off another stone or stones.

This, then, is a brief summary of how curling is played. For more information, send 25c for the booklet, "Curling, Fun For Everyone," by Dar Curtis, 120 El Camino Del Mar, San Francisco, Cal. 94121; or write to *Curling News,* 723 Milwaukee Ave., South Milwaukee, Wis. 53172; or the American Medical Curling Association, 447 South Main, Hillsboro, Ill. 62049.

Curling Provides Exercise

In discussing the psychological value of curling, mention should be made of the exercise the game provides. As Dr. Paul D. White has said in his book, Fitness For The Whole Family (Doubleday, 1964), "It is my experience in dealing with thousands of individuals, healthy and ill, that muscular fatigue for those who can exercise at all is the best antidote that we possess for excessive emotional stress and insomnia, and may be wisely substituted for tranquilizers and hypnotics that so often have undesirable side effects." The exercise in curling is of three sources. First, delivering the 42½ pound stones (done somewhat like delivering bowling balls). Second, walking back and forth on the playing surface. Third and most important, vigorous sweeping (not just "feather dusting"). The sweeping is done so forcefully that in championship play a broom may wear out in only a few games!

The next thing to be said about the psychological value of curling is that it's a game of fun and joy. The importance to health and mental health of recreation, fun and play has been known at least intuitively down through the ages. For instance, the following is quoted from Plato's eighth book of *Laws*: "What, then, is the right way of living? Life must be lived as play, playing certain games, making sacrifices, singing and dancing, and then a man will be able to propitiate the gods, and defend himself against his enemies, and win in the contest."

Many physicians who recommend more physical activity have learned that any regimen of exercise is doomed to failure if the activity is not fun. Hence a program of calisthenics rarely lasts for any significant period of time. And how long the interest in jogging will last is doubtful.

According to Paul Haun, psychiatrist, in his book, Recreation: A Medical Viewpoint (Bureau of Publications, Teachers College, Columbia, 1965) "Play as a primary biologic activity and as an elementary human need has always existed. This need has taken on new poignancy in contemporary times, both as a sane and healthy relief from mounting anxiety and as a sovereign corrective for one-sided vocational, social and cultural tendencies built into our civilization." He says that no one has ever been able to show that play is the outgrowth of some more fundamental urge. It needs no other justification than is to be found in the act itself. It is strictly analogous in this respect to the reproductive drive. This is not to say that such primal urges are not put in the service of other human activities and needs.

Haun believes that the need of sensory input helps to explain why recreation or play or having fun is such a basic human need. The isolation research of Hebb and Lilly, the anaclitic depressions studied by Spitz, and the studies of monkeys raised in Harlow's laboratories at Wisconsin all confirm the importance of sensory input, if the central nervous system is to function normally. Haun theorizes that the *kind* of sensory input is as important as the amount. And he makes the analogy of food intake, that there has to be a "balanced psychic diet."

But regardless of the theoretical explanation of why participant sports are of psychological value, it is a clinical fact that sports, along with other expressive modalities of therapy, have been found useful in enlightened mental hospitals at least as far back as Celsus, a Roman physician in the time of Julius Caesar.

Every curler knows that the sport is fun and I won't go into the why of it except to list some of the elements that contribute to the fun. 1. The challenge of mastering the neurosmuscular skill needed to control both the distance and direction of a 42½ pound stone which must be delivered precisely 35 to 44 yards on ice but which doesn't travel straight. 2. Mastering the variables of the sheet of ice. 3. Competition. 4. Team participation. 5. Strategy. 6. Learning, by the skips, the skills and shortcomings of all eight players. 7. Uncertainty, suspense and luck. Upsets of the experts are frequent. No team can be sure in advance of winning. Those whose self-esteem depends upon winning have no difficulty in rationalizing their losses in curling. ("They were lucky.") 8. The rudiments can be learned readily, but it takes years to master the fine

points. 9. Camaraderie, including "broom stacking," the equivalent of golf's "nineteenth hole." Probably no other sport stimulates more friendliness and sociability.

Relief of Tension

Another important value of curling as a participant sport is the release of tensions—particularly excessive competitiveness, aggressiveness and hostilitity. There is an humorous cartoon history of curling which says the game originated from ancient Scottish clans hurling stones at each other in warfare. This theory about curling's origin is not literally true—as far as we know! And yet in a symbolic, psychologic sense it could well be true. For there is much evidence that beneath people's civilized facades are feelings of rage and violence. When these are given too much fuel, or tension, when the psychophysiological system is overloaded, there is trouble of one kind or another, as neurosis, psychosis, somatic illness or overt "acting out." And when such feelings are bottled up too much, or are too repressed, then personality problems usually ensue. There are various ways, both adaptive and maladaptive, of relieving tensions, e.g., in actions, in talking, dreaming and daydreaming, and in psychophysiologic functioning.

Many psychiatrists have emphasized that sports enable inner tensions and conflicts to be relieved. As Karl Menninger has put it, "We do not keep patients playing tennis just to keep them busy, but to enable them to return their aggressions outward and thus to relieve their need for expressions of internal aggressions." Helene Deutsch regards sports as an ideal medium for mastering inner fears by projecting them onto the outside world.

Curling is a competitive sport and so is a good medium for releasing competitive feelings. While it is not a contact sport, it is a good means of expressing aggressiveness and hostility. For this is done symbolically or vicariously when the other side's stones are knocked away. (How exhilerating it is to make take-out shots!) This is more or less akin to hurling stones at each other as in the cartoon history of curling mentioned above.

Boredom is another kind of tension. Curling is an antidote for it par excellence.

The Uniqueness

There are features to curling which make it almost a unique sport psychologically. For one, it can be played by any age group from about 12 to 90. It is excellent as a lifetime "carry over" sport. It is fine as a family activity, one that spans the generations. Also, it is one of the few competitive sports that teen age boys and girls enjoy playing together. It can be played by the infirm as well as the healthy. There is no absolute contraindication to curling other than confinement to bed. Of interest is the Coronary Curling Club, an international society, where its members curl even though they have had coronary attacks. Admittedly, though, they do not sweep vigorously, only "feather dust."

If we were to think of curling as a kind of psychological therapy, it is an activities therapy, and a group one. It is an expressive modality. The traditions associated with curling are ideal for tempering primitive, immature emotions, as excessive aggressive and hostile urges. These include strong traditions of sportsmanship, of respect and courtesy for opponents, of giving them opportunity to play their best; the give and take of play; emphasis on how the game is played rather than overemphasis on winning; amateurism and no professionalism; and the discouragement of playing for large prizes and wagers. In current psychiatric concepts, curling is a good modality for "primary prevention."

In summary, curling is an excellent winter participation sport. It is good exercise and is of psychological value. It is fun and joy to play. It relieves boredom and excess tensions. It is an expressive modality but tempers immature emotions. It provide competition and team play. It encourages sportsmanship and friendliness. It is a "carry over," lifetime sport that spans the generations. No wonder it has become "Canada's winter pastime" and is growing in popularity in many areas of the U.S. ◄

ISMS 134th Annual Meeting
April 3-6, 1974

Conrad Hilton Hotel **Chicago**

Aneurysm of the Gastroduodenal Artery: A Cause of Gastrointestinal Bleeding

By James L. Weese, M.D./Ann Arbor, Mich.

Intermittent gastrointestinal hemorrhage may present a difficult diagnostic challenge. We treated an elderly grand multipara who experienced numerous incidents of occult bleeding and eventually a massive hemorrhage. The source of this patient's bleeding proved to be an aneurysm of the gastroduodenal artery which was supplied by both the gastroduodenal and superior pancreaticoduodenal arteries and which had eroded into the duodenum. Although this lesion is uncommon, it must be entertained in the differential diagnosis for unexplained intermittent bleeding of the gastrointestinal tract.

Case Report

Mrs. C. D., a 79-year-old Black, widowed, Gravida 7, Para 7, retired domestic servant was admitted to the University of Chicago Hospitals February 2, 1972, after vomiting approximately one pint of bright red blood and experiencing a grossly bloody bowel movement. Occult blood in the stools was first noted in October, 1971, when she was hospitalized for recurrent congestive heart failure and a long history of hypertension. At that time, colon and upper gastrointestinal roentgenograms and sigmoidoscopy revealed diverticulosis of the descending and sigmoid colon, a sliding hiatus hernia (without reflux) and hemorrhoids. Admission and discharge hematocrits were 36.5% and 44.3% respectively.

Four grossly bloody bowel movements within two days prompted readmission in November 1971. She denied associated pain. Admission hematocrit was 26%. She was transfused with three units of packed red blood cells and her hematocrit rose to 38%. Serial nasogastric aspirates did not contain blood.

The patient was discharged and did well until January 14, 1972, when she was readmitted because of hematemesis and melena. Hematocrit on admission was 15% and rose to 40% after transfusion with six units of packed red blood cells. Upper gastrointestinal roentgenograms failed to reveal a lesion. Atrophic gastritis and few scattered superficial hemorrhagic erosions were diagnosed by gastroscopy. Abdominal roentgenograms demonstrated a small calcification just to the right of the midline in the upper abdomen. This was thought by the radiologist not to be in the gall bladder. (See Figure 1)

The patient was discharged January 22, with a hematocrit of 43% after three consecutive days in which examination of the stool failed to reveal gross or occult blood.

The patient was asymptomatic when seen in the outpatient clinic on January 28, 1972. Her hematocrit was 23%, but she refused admission. On February 2, 1972, while eating breakfast, she suddenly felt pressure in the left upper quadrant, gagged, vomited approximately one pint of bright red blood, and soon afterwards passed a liquid bowel movement containing dark red blood. She recalled having "dark" stools for several days. She complained of no pain, and did not faint.

On admission, physical examination revealed an obese (80.6 kg) elderly Black female in mild respiratory distress. Pulse was 64 per minute and regular; respirations were 40 per minute; and blood pressure was 120/68 mm Hg. Pertinent physical findings were: pale mucous membranes; grade 3/6 systolic ejection murmur loudest at the apex; clear lung fields; epigastric tenderness; and, diminished bowel sounds. Labora-

JAMES L. WEESE, M.D., is in training in the Department of Surgery at the University of Michigan. Dr. Weese plans to pursue an academic career in general surgery. He is a graduate of the University of Chicago Pritzker School of Medicine.

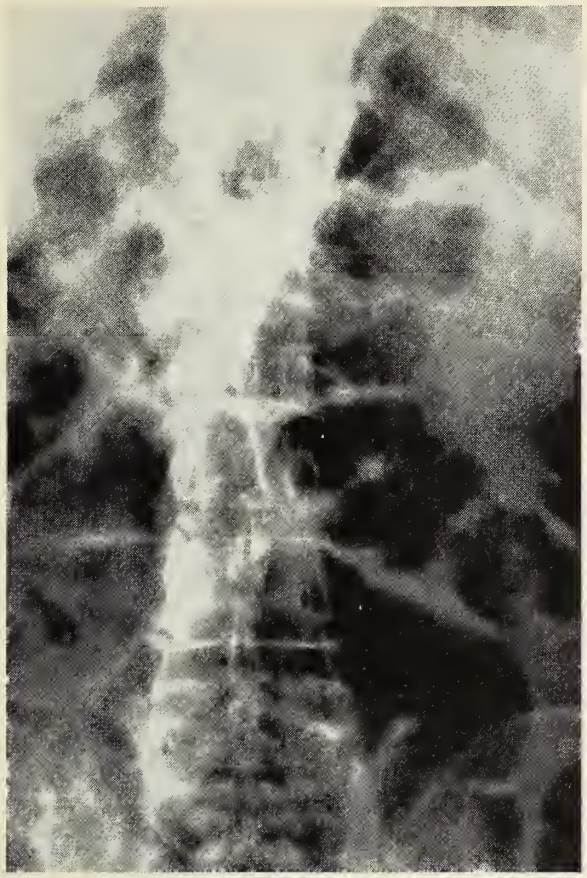


Figure 1. Abdominal flat plate roentgenogram showing circular calcification in right upper quadrant.

tory data: Hematocrit 15.7%; hemoglobin 5.1 gm%; RBC 1.76 million/cc^3; WBC 10,300/cc^3 with normal differential; and platelets 329,000/cc^3. Urinalysis showed 15 WBC's per high power field with moderate gram negative rods. Stools were 4+ benzidine for blood. Electrocardiogram showed complete left bundle branch block.

The patient received two units of whole blood and three units of packed red cells and by the next morning her hematocrit was 33%. On February 4, 1972, she passed a large melanotic stool with dark red clots and, almost simultaneously, bright red blood began to return through the nasogastric tube. The patient became hypotensive with a blood pressure of 70/0 mm Hg., a pulse rate of 80 per minute, and central venous pressure (CVP) of zero. Urinary output ceased. She was given six units of whole blood and underwent emergency laparotomy.

At the operation, the stomach and duodenum were bulging with blood. After a Kocher Maneuver was performed a globular mass could be palpated adherent to the posterior surface of the duodenum. A duodenostomy was accomplished and bright red blood was seen pouring from the upper posterior portion of the duodenum. Dissection revealed an aneurysm of the gastroduodenal artery which was supplied by both the gastroduodenal artery and the superior pancreaticoduodenal arcade. No ulcer was found in the duodenum, but rather, erosion of the aneurysm caused a duodenal mucosal defect. The aneurysm was ligated and resected. (See Figure 2)

A pyloroplasty and cholecystectomy were performed. The gall bladder contained multiple small mottled green-brown stones. The common duct was dilated, but contained no stones. Transfusion of six units of whole blood was required during the procedure to maintain the patient's blood pressure. The post operative hematocrit was 34% and the electrocardiogram remained unchanged. The patient was febrile (39.2°C) that night, but was able to be extubated the following morning.

On the evening of February 5, she became dyspneic and agitated, and her CVP rose to 23 cm. water. Pulse rate was 140 per minute, blood pressure was 90/60 mm Hg., and urine output fell to 20 cc per hour. Her neck veins became distended and a summation gallop was heard. Clinical impression was cardiogenic shock secondary to acute myocardial infarction. Vigorous efforts to maintain blood pressure were unsuccessful and the patient expired 63 hours after surgery. Permission for autopsy was refused.

Pathology Findings

The surgical specimen was a 2 x 1.5 x 1.2 cm

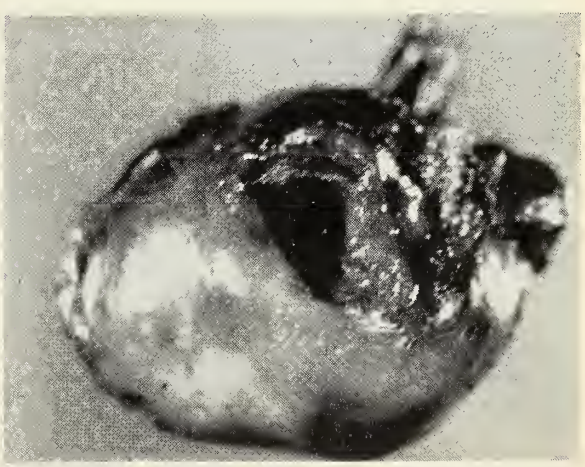


Figure 2. Resected aneurysm showing mucosal defect at site of erosion into the duodenum.

saccular aneurysm with a 0.3 x 0.4 cm lumen at the point of erosion into the duodenum. Numerous small vessels fed into the aneurysm. The sac was filled with a firm gray-brown thrombus.

The wall, fibrillar, and gray-brown in color, varied in thickness from 0.15 to less than 0.1 cm. It was composed almost totally of dense collagen with focal calcification and scattered strands of fragmented elastic tissue. No microorganisms were evident in Gomori-methenamine-silver or Gram stains of the aneurysm.

Discussion

Spontaneous hemorrhage from visceral arteries a condition once named by Hartley and MacKechnie as "splanchnostaxis" is rare. The gastroduodenal artery is an infrequent source of bleeding. Only 13 cases of gastroduodenal artery aneurysm were found in a search of the English literature.[2-7] An aneurysm of the gastroduodenal artery supplied by both the gastroduodenal and superior pancreaticoduodenal arteries has not previously been described. In several large series of cases of "abdominal apoplexy" the incidence of bleeding from this vessel ranged from 2.4%[8] to 4%.[4] Stanley, Thompson and Fry, reporting the largest series of gastroduodenal artery aneurysms suggest arteriosclerosis to be the usual etiology, although they acknowledge reports of trauma and dissection as possible causes.[7] In their collection of 120 hepatic artery aneurysms, Guida and Moore list as the most common etiologies (103/120): 1) systemic infection; 2) arteriosclerosis; 3) cholecystitis and cholelithiasis; and 4) trauma.[9] Similarly Abrams et al suggest the possibility of pancreatitis with chronic inflammation as a cause for gastroduodenal artery aneurysm.[2]

The largest group of splanchnic artery aneurysms are reported in the splenic artery. Stanley, Thompson and Fry reviewed 258 cases in the past decade finding that these aneurysms were classically observed in elderly multiparous females, and invariably were saccular—most frequently resulting from medial wall degeneration.[7] Their picture is remarkably similar to the present patient.

A "classic case" of gastroduodenal artery aneurysm cannot be described. Youngest reported case was a 34-year-old man; our patient (age 79) is the oldest. Presenting symptoms include abdominal or epigastric pain, obstructive jaundice, and hemorrhage. Especially in elderly individuals, right upper quadrant calcifications seen on abdominal roentgenograms—not associated with the gall bladder—may suggest the diagnosis.

The importance of aggressive therapy at the time of original diagnosis is revealed by published statistics. Of the five reported patients undergoing elective aneurysmectomy there were no deaths. In two patients aneurysms were discovered at post mortum examination after massive hemorrhage. Of the seven patients requiring emergency laparotomy for hemorrhage there were four survivors—a mortality rate of 43%.

Aneurysm of the gastroduodenal artery should be considered in any patient who presents with upper or lower gastrointestinal bleeding of undetermined etiology. Once the diagnosis is suspected, particularly in the presence of right upper quadrant calcification on roentgenograms, confirmation may be possible by arteriography and corrective surgery must be undertaken. ◄

References

1. Hartley H., MacKechnie D. M.: A Case of 'Splanchnostaxis.' *Lancet*, 1:289, 1934.
2. Abrams R. M., Kulkarni A. V., Beranbaum E. R., Santos J. S.: "Aneurysm of the Gastro-Duodenal Artery." *Br. J. Radiol* 42:384-385, 1969.
3. Brewer A. D., Marcus R: "Massive spontaneous intraperitoneal haemorrhage. *Brit. J. Surg.* 36:198-200, 1948.
4. Browne M. K., Glashan R. W.: "Abdominal Apoplexy." *Brit. J. Surg.* 52:362-367, 1965.
5. Dvorak A., Gazzaniga A.: "Dissecting Aneurysm of the Gastroduodenal Artery." *Ann. Surg.* 169:425-428, 1969.
6. Hirsch S.: "An unusual Case of Abdominal Apoplexy." *Med. Rec.* 156:39-40, 1943.
7. Stanley J. C.; Thompson N. W.; Fry W. J.: "Splanchnic Artery Aneurysms." *Arch. Surg.* 101:689-697, 1970.
8. Carter R., Gosney W. G.: "Abdominal Apoplexy." *Amer. J. Surg.* 111:388-397, 1966.
9. Guida P. M., Moore S. W.: "Aneurysm of the Hepatic Artery. Report of Fve Cases with a Brief Review of the Previously Reported Cases." *Surgery* 60:299-310, 1966.
10. Foord A. G., Lewis R. D.: "Primary Dissecting Aneurysms of Peripheral and Pulmonary Arteries." *Arch. Path.* 68:553-577, 1959.
11. Ralston L. S., Wasdahl W. A.: "Isolated Dissecting Aneurysms. *Arch. Int. Med.* 105: 935-938, 1960.
12. Reuter S. R., Fry W. J., Bookstein J. J.: "Mesenteric Artery Branch Aneurysms." *Arch. Surg.* 94:497-499, 1968

Planning a Trip to Washington, D.C.?

If you are planning a trip to the nation's Capitol city why not stop and see your Congressmen. Let the ISMS headquarters make appointments for you with your Congressmen. Write or call: ISMS, Governmental Affairs, 360 N. Michigan Ave., Chicago, 60601; 312-782-1654.

Brown Recluse Spider Bite

Increasing Incidents in Northern Illinois

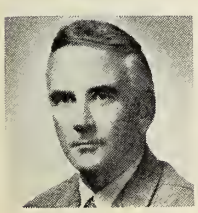
By Robert Simmons, M.D. and John W. Curtin, M.D., F.A.C.S./Chicago

The Brown Recluse spider, *Loxosceles Recluses,* whose bite produces a characteristic necrotic skin slough and sometimes severe systemic reactions, has invaded Northern Illinois. The spider is native to the South Central U.S. and was first identified in Illinois in 1957. Atkins, Wingo and Associates[1] were the first to recognize the bite of the Brown Recluse as the cause of gangrenous skin lesions. Dr. John Enzicker of the Illinois Natural History Survey has reported identification of the Brown Recluse in 36 counties in Illinois (Table I), and it probably has an even wider distribution. Since 1964, at least seven cases have been identified in the Chicago area.

The Brown Recluse spider is small, measuring 3/8 to 1 inch in length. It is light tan to dark brown in color with three sets of dark brown legs on its cephalothorax. The characteristic identifying feature is a dark, violin shaped marking on the dorsum of the spider, with three sets of eyes in the most anterior portion of the violin (Fig. 1). Its natural habitat is out-of-doors in the warmer southern climate. The species probably has migrated north, hidden in shipments of lumber or household furnishings. The spider does not tolerate temperatures below 40 degrees and has, therefore, adapted itself to an indoor environment in the colder northern climates. Here the spider is found in attics, old clothes boxes or heated garages. It is a nocturnal animal and aggressive only when disturbed or when raising its young. Although the number of spiders in the northern climate is small, the movement of the spider to the indoors has brought it into closer contact with humans and will probably result in



ROBERT D. SIMMONS, M.D., a plastic surgean, maintains a private practice in Portland, Oregan. A graduate of St. Louis University Medical Schaal, Dr. Simmans specialized in plastic surgery at the University of Illinois and Rush-Presbyterian-St. Luke's Hospital, Chicaga.



JOHN W. CURTIN, M.D., is Professar and Chairman of the Department of Plastic and Reconstructive Surgery at Rush Medical Callege and Rush-Presbyterion-St. Luke's Medical Center, Chicogo. Dr. Curtin is Past President af the American Cleft Palate Association and is Certified by the American Board of Plastic Surgery. He is a groduate of the University of Pittsburgh Schaal af Medicine.



Figure 1. The Brown Recluse Spider

more clinical cases. Envenomization in the northern climates usually results when persons try on old clothes or clean the attic or garage. Both the male and female Brown Recluse spider bite are toxic.

Although rarely fatal, Brown Recluse venom may cause extensive damage and sloughing of skin and underlying tissues in an area far beyond the location of the bite. In most cases, the tissue defect is so great as to require skin graft coverage.

The purpose of this article is to recount our personal experiences with the wound of the Brown Recluse and to alert all physicians in the State of Illinois of the pathogenesis and treatment of this condition. It is imperative that those physicians practicing in Northern Illinois know that the spider has been migrating into Northern Illinois in increasing numbers.

TABLE I

Counties Where the Brown Recluse Spiders Have Been Identified

Adams	Jefferson
Alexander	Madison
Champaign	Marion
Christian	Mason
Clark	Massac
Clinton	Monroe
Coles	Moultrie
Cook	Perry
Crawford	Piatt
Douglas	Pike
Edgar	Pulaski
Edwards	Randolph
Effingham	Saline
Franklin	Sangamon
Gallatin	Shelby
Hamilton	Union
Jackson	Wayne
Jasper	White

Case Reports

Case 1. J.H., a 50-year-old white male physician was admitted to Presbyterian-St. Luke's Hospital in Chicago on September 6, 1970. The patient stated that two weeks prior to admission, while cleaning a newly constructed home, he noticed a stinging sensation over the dorsal aspect of his proximal right ring finger. The stinging sensation rapidly subsided and went unnoticed until six hours later. The patient was awakened by a dull aching pain on the dorsal aspect of his right hand which progressed throughout that night. The following morning the pain was intense, requiring narcotics for relief. He noticed a blister at the site of the bite with surrounding erythema extending to the dorsal aspect of the hand. The entire hand was swollen.

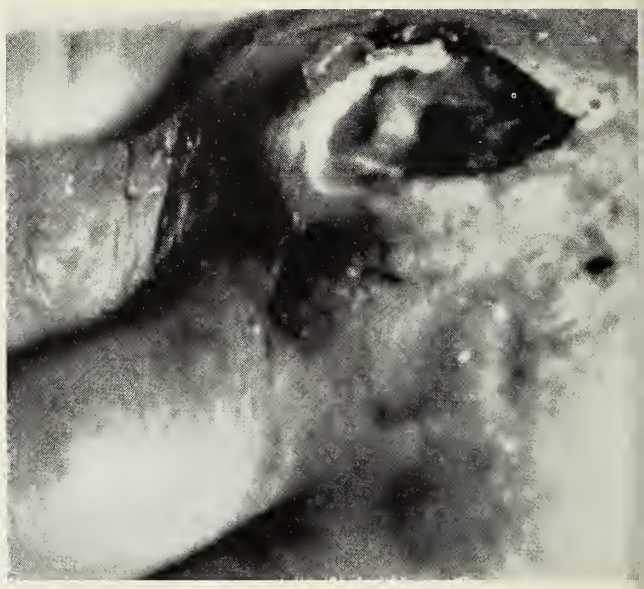


Figure 2

The patient was aware of the presence of spiders in the home (later identified as Brown Recluse) and suspicious that the symptoms were due to a spider bite he began taking antihistamines (Benadryl) and cortisone (Decadron). The pain subsided somewhat and the swelling and erythema remained unchanged until the 4th post-bite day, when the edema and erythema was noted to extend to the elbow. The pain was again intense. The patient then sought the advice of another physician and was hospitalized. On admission, he was noted to have, in addition to the edema, a faint maculopapular rash and a well-formed eschar on the dorsal aspect of his hand. Culture of the eschar grew coagulase positive staphylococcus and the patient was started on antibiotics (Declomycin). He was continued on the antihistamines and cortisone.

The patient failed to respond to the above therapy and was transferred to Presbyterian-St. Luke's Hospital 13 days following the injury. On admission he was noted to have an oral temperature of 101 degrees, pulse of 124 and blood pressure of 135/85. His WBC was 23,200 with a BUN of 28 and a fasting blood sugar of 90. EKG revealed a sinus tachycardia. On physical examination, the patient appeared to be septic. He was confused mentally and appeared flushed. The right hand was swollen with a well-formed eschar on the dorsal aspect measuring 4x6 cm. (Fig. 2). The erythema and induration extended to his axilla and there were tender axillary nodes palpable. The patient was dehydrated.

During the first 12 hours of hospitalization, the patient was hydrated and started on intravenous



Figure 3



Figure 4

Oxacillin. The cortisone and Benadryl were discontinued. When hydration was adequate, the patient was taken to the operating room for debridement of the eschar of the hand and drainage of the suspected forearm and arm abscess. At surgery, approximately 1200 cc. of bloody purulent material was removed from the forearm and arm. The patient had extensive subcutaneous fat necrosis and the entire skin of the forearm was separated from the underlying fascia. The forearm was opened widely and catheters were inserted for continuous irrigation of the subcutaneous space (Fig. 3). The patient responded well to the above therapy and on the 5th postoperative day, his irrigation was discontinued and compression dressings instituted. His WBC had fallen to 8,500 and hemoglobin was 10.4. All evidence of sepsis had disappeared. He was kept on i.m. Oxacillin until his 10th postoperative day and then was discharged.

He returned to the hospital one month later for skin grafting to the open wound of the forearm. The patient required extensive physical therapy, but at three months had full return of function and has returned to work.

Case 2. R.R., a 69-year-old white female was admitted to the University of Illinois Hospital in Chicago on January 27, 1972. The patient had been bitten in the left leg by an insect 10 months prior to admission when visiting a home that was being sprayed for Brown Recluse spiders. The patient noted the onset of pain the following morning, but it was not severe. A firm eschar developed about the eighth day.

The patient was treated initially with antibiotics, elevation and bedrest. Ten months following the bite, the eschar was still in place. She was then transferred to the University of Illinois Hospitals in Chicago.

On admission to the hospital, the patient was noted to have a 4x4 cm, eschar on the posterior aspect of her left ankle. Debridement of the ulcer exposed the Achilles Tendon (Fig. 4).

She was treated with wet-to-dry dressings, and on her 5th post-admission day, was taken to the operating room for further debridement. A split-thickness skin graft was applied to the Achilles Tendon after removal of the necrotic tendon. The skin graft healed and the patient was discharged on February 25, 1972.

Discussion of Clinical Manifestations

The bite of the Brown Recluse spider produces a severe necrotizing cutaneous slough at the site of envenomization. The venom does not spread via the lymphatics, but rather by gravity, probably due to a hyaluronidase present in the venom. The bite usually occurs on the extremity and is painless or produces only a slight stinging sensation. If the spider is not recognized, the bite will usually go unnoticed. Within 4-to-8 hours, an area of erythema appears around the site of envenomization. This erythematous area becomes indurated rapidly and a small bleb may be noticed at the center. The size of the lesion will depend upon the amount of venom injected, but is usually about 0.8 cm. Pain becomes a prominent feature of the syndrome at this stage. It is mild at first, but then becomes more intense and requires narcotics for relief. The pain usually continues until the eschar is formed, at 48-to-72 hours. The erythematous area begins to blanch and become mottled. Areas of subcutaneous hemorrhage may occur. At 2-to-3 days, an avascular area is well formed and begins to mummify. Fortunately, the venom usually involves only skin and subcutaneous tissue. The eschar, when formed, is slow to separate and healing is retarded. Spontaneous healing usually requires 6-to-8 weeks, and in one of our patients, the wound was not healed at 10 months.

Although the cutaneous manifestations of the Brown Recluse spider bite are characteristic, systemic reactions may occur and are occasionally fatal. Fortunately, fatalities are rare but usually occur in children. Systemic effects of the venom begin at 12-to-24 hours in the form of chills, fever, nausea and vomiting. This is followed by a generalized macular and sometimes petechial rash. The venom also appears to have a hematolytic effect in susceptible individuals. In severe bites, the hemolysis may be severe with anemia, hemoglobinuria and renal failure. Most of the deaths reported have been due to the renal complications of the hemolysis.

Treatment

Early excision and closure of the bite wound during the erythematous phase appears to be the most-effective form of treatment. Fardon, D. W., Masters, F. W., et al.,[2] have shown that early total excision of all involved tissues was uniformly successful in preventing both local and systemic manifestations of the bite in experimental animals. This type of treatment must be instituted early to be effective, usually **within four-to-six hours** after the bite. This type of therapy would, therefore, depend upon identification of the spider or recognition of the classical clinical manifestations of the disease. Once the eschar has become established, excision and grafting is the preferred form of therapy. At 6 or 7 days, the full extent of the cutaneous loss can be identified and should be excised. Generally, it is not necessary to excise beneath the fascia. Grafting may be difficult, but will greatly speed recovery.

Treatment of the systemic effects of the venom would best be by antivenom, but none is, as yet, available. Dillaha and Associates[3] have found that steroids given to experimental animals within 8 hours after the bite have been effective in preventing the systemic reactions. If steroids were delayed for 24 hours, they did not appear to be effective. Clinical experience would support these findings. Antihistamines also have been popular in clinical treatment of Brown Recluse spider bites and appears to reduce the systemic reaction. Fardon, D. W. et. al.,[2] found that antihistamines were of no value in the treatment of experimental animals, nor was Phentolamine or Low Molecular Weight Dextran. Neither antihistamines nor cortisone have any value in reducing the cutaneous slough. Supportive measures should include tetanus prophylaxis and antibiotics.

In one of the cases presented, the most prominent part of the clinical picture was the severe infection that had been masked by the use of cortisone. Position of the extremity is important. Since the venom spreads by gravity, areas such as flexion creases should not be put in a dependent position.

Summary

- The Brown Recluse Spider, *Loxoscles Recluses,* has been seen in the northern sections of Illinois in increasing numbers. This is substantiated by the number of bites being reported in humans.
- Early excision of the area of the bite within the first four-to-six hours offers the most-effective treatment.
- An antivenom has not, as yet, been developed.
- There is a need to alert all physicians in the State of Illinois to the presence of the Brown Recluse Spider and to its proper prompt therapy. ◄

References

1. Atkins, J. A., Wingo, C. W., Sodeman, W. A. and Flynn, J. E. "Necrotic Arachnidism." *Am. J. Trop. Med.,* 7:165, 1958.
2. Fardon, D. W., Curtis, W. W., Robinson, D. W., and Masters, F. W. *Plastic and Reconstructive Surgery* 40:482, 1967.
3. Dillaha, C. J., Jansen, G. T., Honeycutt, W. M. and Hayden, C. R. "North American Loxoscelism." *JAMA* 188:33, 1964
4. Hershey, F. B. and Aulenbacher, C. E. "Surgical Treatment of Brown Spider Bites." *Ann. Surg.* 170:300, 1969.
5. James, J. A., Sellars, O. A., Austin, O. M. and Terrill, B.S. "Reactions Following Suspected Spider Bites." *Amer. J. Dis. Child.* 102:395, 1961.
6. Sprugel, G., Jr. "Illinois Natural History Survey." Release—Urbana, Illinois. Jan. 12, 1968.

Disposal of Records After Retirement

From an ethical point of view a physician is under no obligation to turn his records over to his patients. In the best interest of the patient, however, when a physician contemplates moving from a community or retiring from practice, he might notify the patients on his active list of the fact that he intends to leave and encourage the patient to seek the services of some other doctor of medicine. The physician could also suggest that, with the consent of the patient, arrangements can be made to permit a succeeding physician, designated with reasonable time by the patient, to review these records. In this way the patient's best interests may be served.—*Opinions And Reports, Judicial Council of the AMA.*

Common Problems in High Risk Nurseries

By Rosita S. Pildes, M.D./Chicago

During the past decade, there has been striking progress in the diagnostic and therapeutic measures developed for the care of the high risk newborn infant.

While the newborn nursery for normal term infants with its bassinets, occasional nurses and visitors' windows, closely resembles the nursery of 10 years ago, the special care nursery of today is strikingly different. Sophisticated incubators, monitoring equipment for respirations and heart rate with alarm systems, complex pumps for the administration of intravenous fluids and intricate apparatus for resuscitation immediately strike the eye of the observer. The nursery is under the direction of a full-time neonatologist. Adequate numbers of specially trained nursers and house staff are in constant attendance. Buttressing the special care nursery of today are clinical chemistry laboratories capable of determinations on microsamples of capillary blood.

An important advance in safeguarding the newborn has been the understanding of the need for protection against heat loss. In most instances, heat can be provided by an incubator. The temperature of the incubator, however, can no longer be set at a specific limit, but should vary with the infant's requirements. Special servo-care units are helpful in maintaining a neutral body temperature of 96-98°F, thus decreasing oxygen consumption in the small premature infant. Radiant heaters should be used in delivery rooms, in operating rooms for cesarean sections or for any procedures such as exchange transfusions which require visibility and ready access to the infant. Despite the constant desire to keep the infant warm, however, must be the realization that over heating or abruptly increasing the body temperature may cause apneic spells. Fever or hypothermia, used as a sign of sepsis, may be obscured by the maintenance of a constant body temperature.

Respiratory Distress

One of the most common causes of death in newborn infants is respiratory distress which accounts for approximately half of the neonatal deaths among viable infants. The determination of respiratory distress by the pediatrician initially called to see the patient is critical in order to avoid loss of time before special treatment is instituted. Clinical appraisal must be supplemented by chest X-ray and laboratory measurements in order to make an accurate diagnosis and to assess the degree of respiratory and metabolic acidosis and the state of oxygenation. Any infant who requires oxygen in concentrations greater than 40% should have serial measurements of arterial PO_2. Safe PaO_2 levels lie between 50-100 mm Hg. The physician who only uses cyanosis as a guide to therapy may often be mistaken in his judgment since there is a well recognized lack of correlation between visible cyanosis and arterial oxygen tension. Since oxygen toxicity to the retina and to the lungs is detrimental for long term prognosis, careful monitoring must be made in order to provide adequate oxygenation to the brain without extensive damage to the other tissues.

Frequent measurements of arterial pH, PCO_2 and PO_2 require the insertion of an umbilical artery catheter. The incidence of complications in umbilical catherizations varies between 1-7%. These complications should decrease since the introduction of the soft catheters with rounded blunt tips and with the increasing experience of those who perform the procedures. Nevertheless, umbilical catheterization should be performed with great caution and the position of the catheter should be checked by X-ray. The arterial catheter should lie in the aorta, below the level of the renal arteries.

When arterial blood gases are not available, warmed arteriolized samples of capillary blood may serve as guidelines for O_2 therapy. These are not as accurate and they require blood gas measuring apparatus which have a special microcapillary attachment. Capillary measurements are particularly reliable when arterial PO_2 is low, and not as accurate when arterial PO_2>65mm Hg.

The maintenance of adequate respirations requires constant vigil to prevent prolonged periods of apnea. Heart rate and respiratory rate moni-

ROSITA S. PILDES, M.D., is Director of Neonatology, Cook County Children's Hospital, Professor of Pediotrics, Abrohom Lincoln School of Medicine of University of Illinois College of Medicine.

tors which will ring an alarm are important adjuncts to the constant vigil which nurses must otherwise provide for every sick neonate in the nursery.

Assisted ventilation is necessary for the infant in respiratory failure. The success of ventilator therapy depends more upon the skills and dedication of nursing and medical staff than on the "hardware" employed to perform the task. In the non-breathing infant, endotracheal or nasotracheal intubation is performed and a positive pressure respirator is used to maintain ventilation. A complication of positive pressure respirators combined with high oxygen concentration, has been the development of broncho-pulmonary dyplasia, a chronic lung disease characterized by changes in the tracheo-bronchial mucous membranes.

In an attempt to decrease pulmonary oxygen toxicity, various methods have been developed for improving arterial oxygenation in infants with R.D.S. These techniques are useful because they avoid the use of endotracheal intubation. They are employed in spontaneously breathing infants who require high inspired oxygen concentrations to maintain an arterial PO_2 within normal limits. The methods also allow the lowering of inspired oxygen concentration rapidly to safer limits. One technique, reported by Gregory et. al[1] employs continuous positive airway pressure (CPAC) applied through a box in which the infant's head has been placed. CPAP may also be applied through an endotracheal catheter. More recently, nasal prongs have been used as a means of administering CPAP. Another technique reported by Vidyasagar and Chernick employs continuous negative pressure (CNP) to the body of the infant in a tank respirator.[2] Vidyasagar and Chernick reported a 70% survival in 49 newborns with severe respiratory distress syndrome requiring assisted ventilation.

Importance of Hydration and Nutrition

In addition to providing adequate thermal protection and the maintenance of adequate respirations, a third main objective in the care of the newborn is to provide sufficient hydration and nutrition, thus preventing the consequences of starvation, such as acidosis which may promote the development of kernicterus or hypoglycemia which may result in brain damage. Hyponatremia, hypernatremia and hypocalcemia must also be identified and corrected. The infant who cannot tolerate oral feedings should receive supplemental intravenous feedings. During the time that blood gas measurements are needed, fluids may be given through the umbilical artery. However, umbilical catheters must be removed as quickly as possible and fluids should then be provided through a peripheral vein. We do not use the umbilical vein unless neither umbilical arteries nor peripheral veins can be cannulated.

Parenteral fluids and calories are sometimes required for a prolonged period of time. When this is the case, nutrients adequate for growth cannot be delivered by the usual intravenous fluid preparations. The technique of hyperalimentation, as developed by Dudrick,[3] has been successful in providing sufficient calories for adequate growth. These results are achieved by infusing a hyperosmolar solution containing protein, glucose, salts and vitamins, at a constant rate through an indwelling catheter placed in the external jugular vein and threaded into the superior vena cava. A constant rate of infusion and infusion into a large vessel is important. Microbial contamination is prevented by meticulous mixing procedures and by the use of millipore filters. Hyperalimentation has proved particularly useful in postoperative surgical newborns who cannot tolerate oral feedings for protracted periods of time.

A modified form of hyperalimentation, utilizing lower concentrations of dextrose and protein and administered through a peripheral vein has been used in our nursery as a means of providing more calories than can be administered with ordinary intravenous feedings.[4] Twenty infants who weighed between 1000-1500 gm at birth and who were given the modified dextrose protein mixture gained significantly more weight than 16 control infants when evaluated at 21 days of life. This technique deserve further evaluation.

Peristaltic pumps are necessary to insure a constant flow, to prevent hypoglycemia, catheter blockage and overhydration of the sick infant. There are a variety of pumps available for this purpose. One of the commercially available pumps is costly, but provides the advantages of monitoring the delivery of fluid using the standard infusion set. In another less expensive pump, the tubes that must be interposed between the infusion set and the patient provide a source of contamination and sterilization procedures must be carefully controlled.

It is obvious, therefore, that the provision of proper temperature control, nutrition and maintenance of respiration alone require a complex team of individuals and equipment. Some of the equipment has already been discussed. These include servo-care incubators, radiant heaters, monitors for heart rate, respiration, temperature, blood pressure, oxygen concentration, and controllers for desired ambient oxygen concentra-

tion. In addition, phototherapy units, Toledo infant scales, infusion pumps, oxygen hoods, resuscitators and ventilators are now standard equipment. Personnel must include full-time neonatologists (approximately one for every 3,000 deliveries), specially trained nurses at a 1:4-1:1 ratio, nursing personnel, neonatology fellows, residents, interns and medical students.

In addition to full-time nursery personnel, ancillary divisions are necessary for immediate action. These include microlaboratory and radiology services which are available 24 hours per day, pediatric cardiologists, surgeons and anesthesiologists.

Personnel Needs

The special care nursery must also provide the need for clinical investigation. This requires objective evaluation by means of controlled studies of newer techniques. Long term assessment of the growth, development and morbidity of survivors must be made.

It becomes obvious that the facilities and personnel needed in each area can only be provided by a few excellent intensive care nurseries, the cost being prohibitive for the average hospital. A state-wide program is being initiated for the provision of intensive neonatal care in regional nurseries located in key areas throughout the State of Illinois. This requires knowledge of vital statistics including the proportion of women in the child-bearing age, their geographic and socioeconomic class distribution. Climatic conditions, transportation routes and natural obstacles must be surveyed. This data will then provide a basis for deciding where regional neonatal centers should be placed. Where premature centers have been available, their ability to provide contemporary care should be examined.

Transport system for sick neonates must be instituted in areas where it is not currently available. In many cases, ambulances can provide the necessary transportation. Ideally, these may serve as mobile intensive care units. Where distances are great, heliocopters can be employed. Transfer should be carried out within the first hours of life or death may occur before treatment can be instituted. The provision of a satisfactory transport service is, therefore, crucial to the success of a regionally organized neonatal referral facility.

Insurance laws and practices should be changed to finance the care of infants needing special facilities.

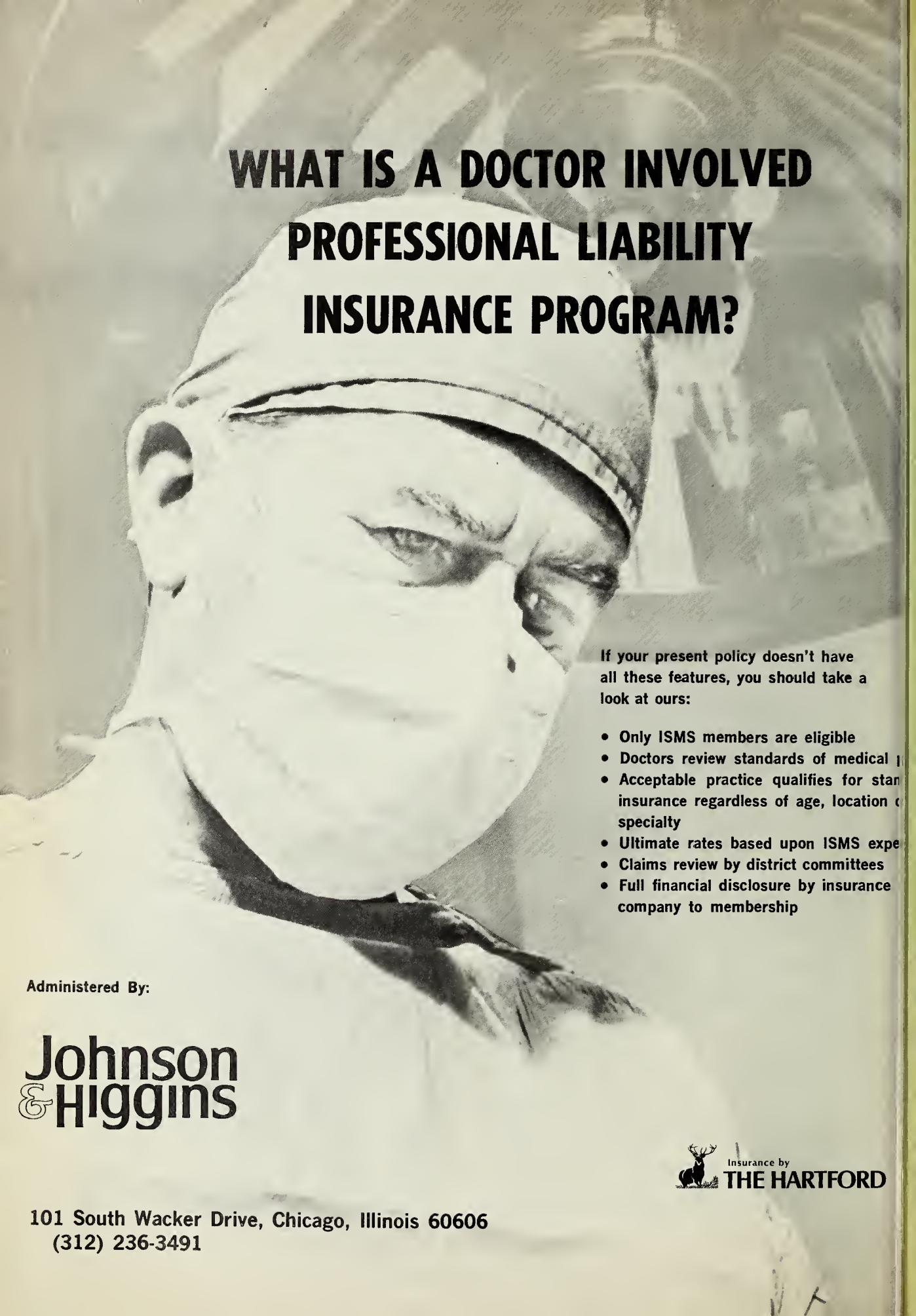
Results to date show a decreased neonatal mortality in regional centers throughout the United States and Canada. Usher's[5] figures for the Province of Quebec in 1968 show that the lowest neonatal mortality was achieved in metropolitan hospitals who had their own intensive care units. Neonatal mortality was slightly higher in metropolitan hospitals who referred infants to the intensive care units and mortality rates were highest in those hospitals who did not have and did not refer patients to intensive care units. There are only a few long term studies on morbidity. In one long term study of developmental outcome of 28 infants with severe hyaline mebrane disease who received assisted ventilation, Stahlman[6] reported normal developmental quotients in all but three infants who weighed less than 2000 gms at birth. Thus, respirator care did not lead to an increased incidence of mental retardation.

It makes sense that prevention of hypoxemia, hypoglycemia and the prompt therapy of metabolic acidosis and electrolyte disturbances should result in a decreased incidence of mental retardation. Although intensive care is expensive, these costs are small when compared to the price of institutionalization.

The involvement of the practicing pediatrician in these programs is healthy and highly desirable. Formal attending rounds by physicians who are responsible for ongoing care and who provide the link between the newborn and his family are necessary to provide a balanced teaching program. In return, the center must keep the pediatric community informed for it is the practicing pediatrician who must decide which infants should be transferred and at what point transfers should be made. By effective use of special care nurseries, we can and should be able to reduce neonatal mortality and the incidence of mental retardation. ◄

References

1. Gregory, G. A.; Kitterman, J. A.; Phibbs, R. H.; Tooley, W. H.; Hamilton, W. K. "Treatment of the Idiopathic Respiratory-Distress Syndrome with Continuous Positive Airway Pressure." *NEJM* 284:1333, 1971.
2. Vidyasagar, D.; Chernick, V. "Continuous Positive Transpulmonary Pressure in Hyaline Membrane Disease A Simple Device." *Pediatrics* 48:296, 1971.
3. Dudrick, S. J.; Wilmore, D. W.; Vars, H. M.; Rhoads, J. E. "Long-Term Total Parenteral Nutrition with Growth, Development, and Positive Nitrogen Balance." *Surgery* 64:134, 1968.
4. Pildes, R. S.; Ramamurthy, R.; Cordero, G. V. and Wong, P. W. K. "Intravenous Supplementation of Pure L-Amino Acids and Dextrose in Low Birthweight Infants." *J of Pediatrics* 82:945-950, 1973.
5. Usher, R. H. "Clinical Implications of Perinatal Mortality Statistics." *Clinical Obstetrics and Gynecology* 14: 885, 1971.
6. Stahlman, M. "What Evidence Exists That Intensive Care Has Changed the Incidence of Intact Survival." Problems of Neonatal Intensive Care Units. Report of the 59th Ross Conference on Pediatric Research 1969.



WHAT IS A DOCTOR INVOLVED PROFESSIONAL LIABILITY INSURANCE PROGRAM?

If your present policy doesn't have all these features, you should take a look at ours:

- Only ISMS members are eligible
- Doctors review standards of medical
- Acceptable practice qualifies for stan insurance regardless of age, location specialty
- Ultimate rates based upon ISMS expe
- Claims review by district committees
- Full financial disclosure by insurance company to membership

Administered By:

Johnson & Higgins

Insurance by THE HARTFORD

101 South Wacker Drive, Chicago, Illinois 60606
(312) 236-3491

Doctor's News

ILLINOIS DIVIDED INTO 7 PSRO REGIONS—The U.S. Department of Health, Education, and Welfare has designated seven PSRO regions for Illinois. Cook County (Region 3) is the largest PSRO area in the state, and one of the largest in the U.S.

ISMS, IFMC and IPSRO had recommended a single PSRO designation for the state. Only 30 jurisdictions were designated as "state wide" PSRO areas.

ISMS Officers and the Executive Committee believe that a special meeting of the House of Delegates may be needed to reassess the society's policy on this controversial issue and to receive guidance of the membership on a firm course of action. Before calling the meeting, however, ISMS urges each county society to hold a special meeting to discuss PSRO. This will afford an opportunity for the delegates to appropriately express the viewpoint of the membership at the meeting. Trustee District meetings also are planned.

A call for a special meeting of the House of Delegates may be issue following the February 3-6 meetings of the Board of Trustees, with the meeting later in February, if one is to be held. Feed back from county societies prior to the Board meeting is important.

Physicians groups wanting to become PSRO's, with authority to control Medicare and Medicaid benefits in their respective areas, should make application to HEW. Upon designation as a PSRO, they receive the necessary funding to carry out their operations. Prior to January 1976, only M.D. organizations may be designated as PSRO's. If no physician organization volunteers to develop PSRO, presumably nothing happens for the next two years.

IDPH WARNS CONSUMERS ON 2 HEALTH FOODS—The Illinois Department of Public Health warns consumers not to use either of two products that are sold primarily in health food stores as special dietary supplements. The products, Aprikern and Bee-Seventeen, are derived from apricot kernels and contain potentially dangerous levels of hydrogen cyanide, the federal Food and Drug Administration (FDA) reported.

Joyce C. Lashof, M.D., Director of IDPH, explained that, according to reports received from the FDA, the ingestion of five Aprikern capsules could result in cyanide poisoning, and be fatal to a child. Twenty such capsules could be fatal to an adult. "FDA also estimates that two packets of the Bee-Seventeen product contain enough hydrogen cyanide to cause cyanide poisoning in a small child," Dr. Lashof added.

HAVE YOU BEEN AN EXPERT WITNESS?—The Forensic Science Foundation is currently conducting a research project, of which the objective is to define and evaluate the various services performed by the forensic science profession in the criminal justice process.

If, since 1972, you have given reports or testimony in criminal court or elsewhere in the criminal justice process as an expert witness for either the prosecution or for the defense, you are asked to mail a card or note, giving your name, address and area of expertise to: Forensic Sciences Foundation, 11400 Rockville Pike, Rockville, Maryland 20852. The Foundation, in turn, will mail to you a short questionnaire designed to group your type and degree of involvement with other individuals who have similar expertise.

This is a federally sponsored research project. The results will not identify any individuals. No form of solicitation will result from individual participants since all names, addresses and questionnaires will be treated as confidential information.

NURSES REQUIRED TO REPORT CHILD ABUSE CASES—Illinois law now requires registered or licensed practical nurses to report to the state Department of Children and Family Services all cases of suspected child abuse within 24 hours.

CORRECTION ON BOARD MEETING DATE—The ISMS Board of Trustees will meet **August 3-4, 1974,** not August 2-3, 1974, as previously reported. The August meeting will be conducted at the Sheraton Oakbrook, Oakbrook.

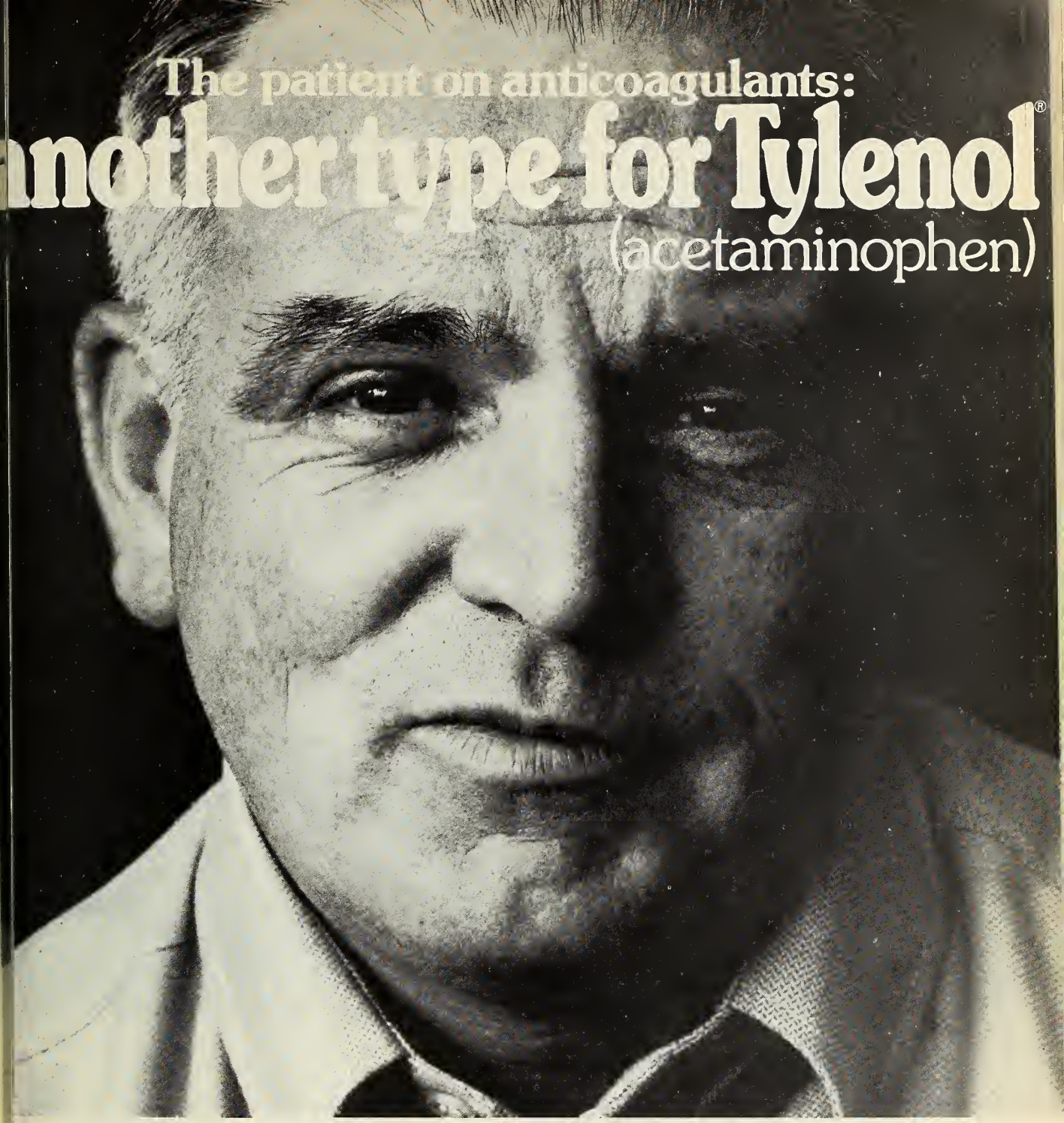
SIX ISMS MEMBERS NAMED TO AMA COUNCILS, COMMITTEES—Joseph Skom, M.D., Chicago, ISMS 3rd District Trustee, has been appointed Chairman of the AMA's new Committee on Drug Abuse. Other ISMS members re-appointed to AMA councils or committees are: **Herman Wing, M.D.,** Chicago and **Newton DuPuy, M.D.,** Quincy, Council on Health Manpower; **Max Klinghoffer, M.D.,** Elmhurst, Committee on Community Emergency Services; **Paul Lazar, M.D.,** Highland Park, Chairman, Committee on Cutaneous Health and Cosmetics; and **Maurice Hoeltgen, M.D.,** Committee on Insurance.

PHYSICIANS IN THE NEWS—Jeremiah Stampler, M.D., Chairman of the Northwestern University Medical School Department of Community Health and Preventive Medicine, has been named the first Harry W. Dingman Professor of Cardiology.

Roland I. Pritikin, M.D., Rockford, recently was elected as a Fellow in the American College of Nuclear Medicine.

Marshall Falk, M.D., Chicago, has been named as Acting Chairman of the Department of Psychiatry and Behavorial Sciences at the University of Health Sciences/The Chicago Medical School.

Richard E. Blanton, Ph.D., Springfield, is the new Deputy Director for Developmental Disabilities of the Illinois Department of Mental Health and Developmental Disabilities.



When the patient on anti-
gulant therapy has a condition
uiring an analgesic, a new problem
es. Aspirin frequently causes
longed bleeding time and occult
trointestinal bleeding.[1,2]

TYLENOL (acetaminophen)
vever, is unlikely to produce either
ction[2,3] and is therefore the
ferred analgesic for the patient with
morrhagic tendencies and
patient receiving anticoagulant
rapy.

The patient on anticoagulants
nly one of several 'types for TYLENOL'–that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Koch-Weser, J., and Sellers, E.M.: New Eng. J. Med. *285*:447-458 (Sept. 2) 1971. **2.** Udall, J.A.: Clin. Med. *77*:20-25 (Aug.) 1970. **3.** Mielke, C.H., Jr., and Britten, A.F.H.: New Eng. J. Med. *282*:1270 (May 28) 1970 (corresp.).

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

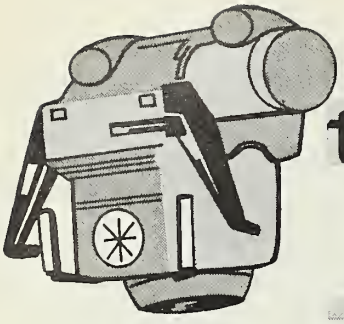
Supplied: Tablets, 325 mg.
For Children:
Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin,
yet just as effective for relief
of pain and fever

Tylenol®
(acetaminophen)

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

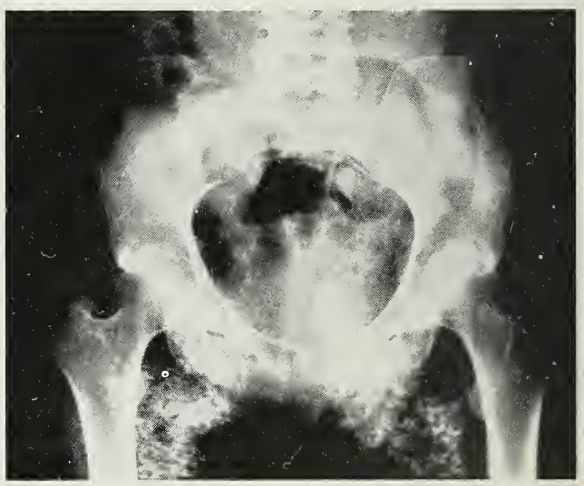
© McN. 1973



the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine



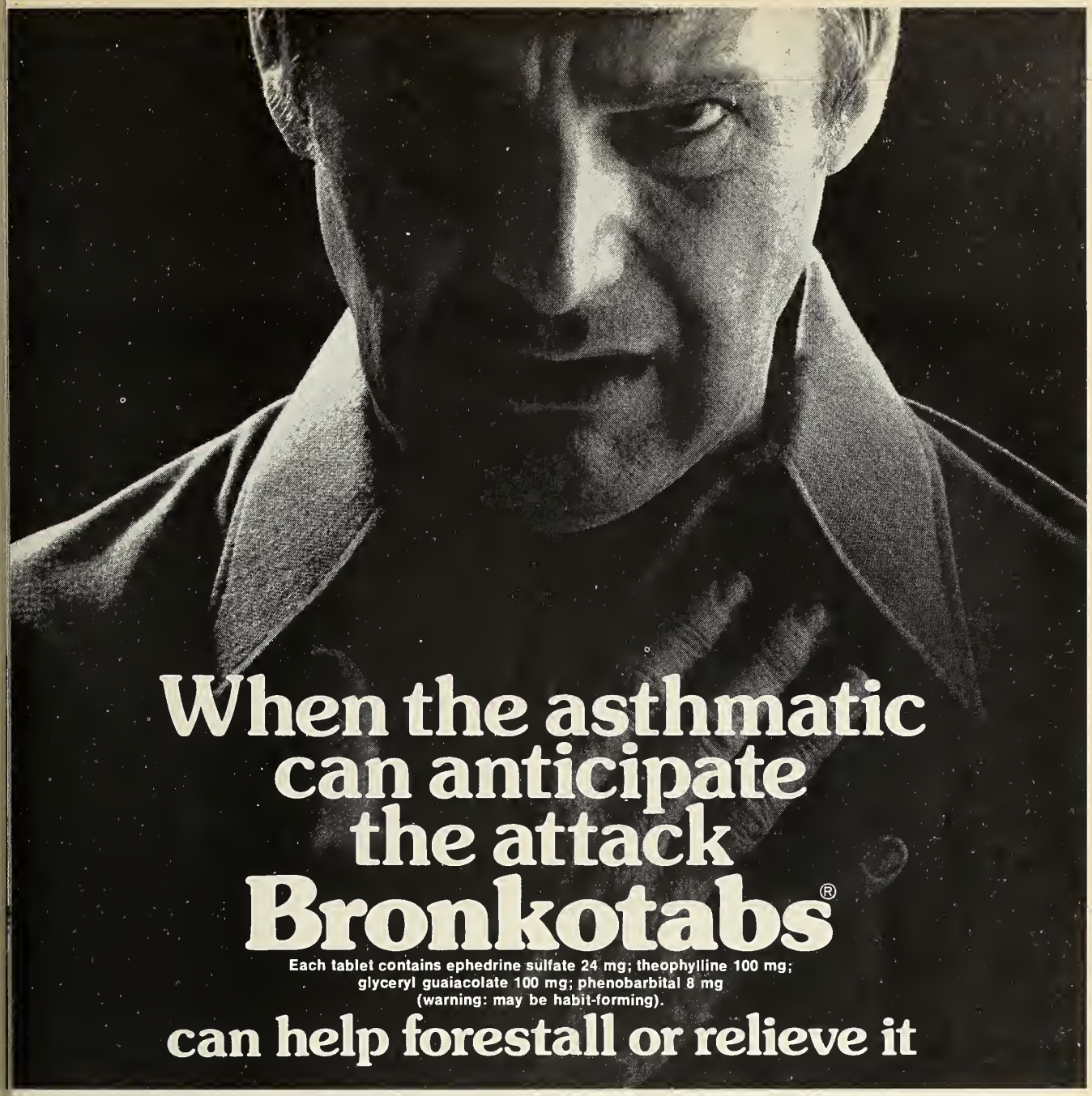


The patient is a 29-year-old white female whose chief complaints were muscle weakness and pain. Physical examination revealed an erythematous rash over the anterior chest. There was muscle weakness involving the arms and legs.

What's your diagnosis?

1. Hyperparathyroidism
2. Scleroderma
3. Subcutaneous Fat Necrosis
4. Dermatomyositis

(Answers on page 77)



When the asthmatic can anticipate the attack Bronkotabs®

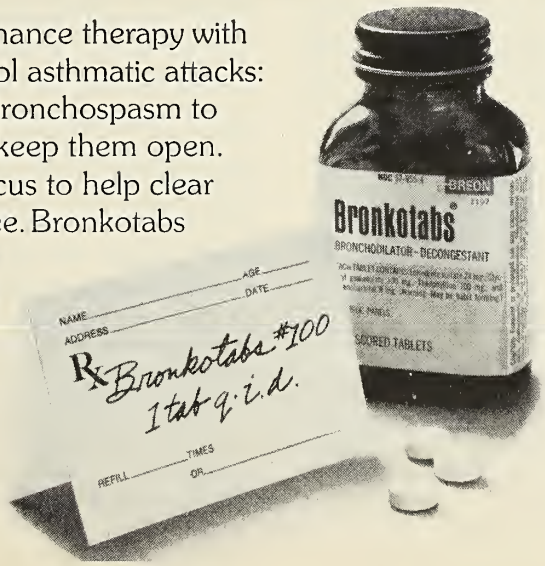
Each tablet contains ephedrine sulfate 24 mg; theophylline 100 mg; glyceryl guaiacolate 100 mg; phenobarbital 8 mg (warning: may be habit-forming).

can help forestall or relieve it

Why day to day maintenance therapy with Bronkotabs helps control asthmatic attacks:

Bronkotabs relieves bronchospasm to open airways and help keep them open.

Bronkotabs thins mucus to help clear the tracheobronchial tree. Bronkotabs decongests bronchiolar mucosa to improve the passage of air. Economical long-term therapy.



PRECAUTIONS AND ADVERSE EFFECTS: Sympathomimetic side effects are minimal, and there are none of the dangers or side effects associated with steroid therapy. However, frequent or prolonged use may cause nervousness, restlessness or sleeplessness. Should be used with caution in the presence of hypertension, heart disease or hyperthyroidism. Drowsiness may occur. Ephedrine may cause urinary retention, especially in the presence of partial obstruction, as in prostatism.

DOSAGE: Adults, one tablet every three or four hours, four or five times daily. Children over six, one-half the adult dose. Children under six, as directed.

SUPPLIED: Bottles of 100 and 1,000 tablets.

BREON

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

Cardiovascular Collapse During Gynecological Laparoscopy

By A. D. Ivankovich, M.D., R. F. Albrecht, M.D., B. Zahed, M.D. and R. F. Bonnet, M.D./Chicago

Laparoscopy is at the present time a widely accepted procedure, used with increasing frequency for both diagnostic and therapeutic purposes. The procedure generally has been shown to be safe. However, the deliberate induction of pneumoperitoneum can affect cardiovascular homeostasis and could be a possible source of serious complications.[1-3] During the past several years we have heard of several cases of cardiac arrest during laparoscopy, but we have been able to find only a few such cases reported in the literature.[4-7]

The purpose of this paper is to report four cases of cardiovascular collapse during laparoscopy which occurred in three different hospitals within the last two years and to call attention to some of the potential hazards of the procedure.

Case 1

A 24-year-old woman was admitted to the hospital because of a left adnexal mass. During the last several years she was treated intermittently with estrogens for amenorrhea. The treatment had to be discontinued each time because of troublesome edema. A year prior to this admission she was operated under general anesthesia for removal of impacted wisdom teeth.

Physical examination revealed a short statured female with a webbed neck. The blood pressure was 110/74 mmHg, and the heart rate 84 beats/min. An IVP showed absence of the right kidney and malrotation and enlargement of the left kidney. Preoperative laboratory values, chest roentgenogram and electrocardiogram were within normal limits.

Premedication consisting of morphine (6.0mg) and atropine (0.4mg) was given an hour before the start of anesthesia.

On arrival in the operating room the patient appeared well sedated. Anesthesia was induced with thiopental sodium, 200mg. Succinylcholine, 80mg, was given to facilitate endotracheal intubation. Anesthesia was maintained with halothane 1-2% and nitrous oxide 60%, using a semiclosed system and intermittent positive pressure breathing. The blood pressure was 110/76 mmHg prior to induction, 140/80 mmHg after tracheal intubation and 100/68 mmHg at the start of the operation.

The patient was placed in the lithotomy position, and the abdomen was prepped and draped in the routine manner. After the peritoneal cavity was distended with carbon dioxide, the patient was placed in the Trendelenburg position and a trochar was inserted below the umbilicus into the abdomen. The amount of carbon dioxide used for the insufflation and intraabdominal pressure were not monitored. However, the abdomen did not appear to be overdistended. Shortly after the laparoscope was introduced into the abdomen (25 minutes after the start of anesthesia) the blood pressure became unobtainable and a carotid pulse was absent.

All instruments were withdrawn and carbon dioxide was released from the peritoneal cavity. The patient was placed immediately in the flat supine position and all anesthetics discontinued. Following these measures, a carotid pulse became palpable and the systolic pressure was obtained at 50 mmHg. During the next few minutes, the blood pressure increased to 110/90 mmHg and the patient began to breath spontaneously. Following the intravenous administration of doxapram, 60mg, respiration improved markedly and the patient was extubated and transferred to the recovery room. The postoperative course was uneventful and the patient was discharged on the third day.



ANTHONY D. IVANKOVISH, M.D., is Assaciate Prafessor in Anesthesiology, University af Chicago, and Attending Anethesialogist at Michael Reese Haspital and Medical Center, Chicago. He is a Diplamate af the American Baard af Anesthesialagy, member af the American Society af Anesthesiology and International Anesthesia Research Saciety.

R. F. ALBRECT, M.D., B. ZAHED, M.D., and R. F. BONNET, M.D., alsa are fram the Department af Anesthesiology, Michael Reese Hospital and Medical Center.

Case 2

A 29-year-old woman was admitted to the hospital because of vaginal bleeding and pain in the left lower abdomen. The patient gave a history of uneventful pregnancy 11 years earlier. She had been married for the last one and a half years, and despite not using any form of contraception, she failed to conceive. The patient gave a history of several epidoses of acute PID and irregular menses. LMP started two weeks before and continued until admission.

Physical examination on admission revealed an underweight young woman in no acute distress. Blood pressure was 110/70 mmHg; pulse was irregular, 86 beats/minute. There was tenderness and a palpable mass in the left lower quadrant. All laboratory tests, except slight elevation in WBC, were within normal limits. The impression was that the patient had resolving pelvic inflammatory disease and she was placed on antibiotics and bed rest.

On the third hospital day the patient was taken to the operating room to have a dilatation and curretage, laparoscopy and possible laparotomy. Premedication consisted of meperidine 100mg, atropine 0.4mg, given an hour prior to surgery. Preoperative blood pressure was 110/70 mmHg and the pulse rate 90/minute. Anesthesia was induced with Innovar 2½ml and maintained with nitrous oxide 50% using a semi-closed rebreathing system. The patient was placed in a dorso-lithotomy position and dilatation and curettage performed in the usual manner. Following this the tubal patency apparatus was inserted into the cervix and CO_2 insufflation begun under moderate pressure. No abdominal distention was noted, and it was decided to insufflate CO_2 transabdominally and do a laparoscopy. A Verres needle was then inserted below the umbilicus and CO_2 was insufflated at a slow rate. The small periumbilical incision was made and a peritoneoscope trochar was inserted into the abdominal cavity. As soon as the peritoneoscope was inserted, marked bradycardia was noted. The patient was placed immediately in the horizontal position, CO_2 was expressed, the trachea intubated, controlled respiration started and atropine 0.4mg was given intravenously. The heart beats became slower and then disappeared. External cardiac massage was started and sodium bicarbonate, calcium chloride and epinephrine administered intravenously. A cardioscope was attached and initially showed very slow idioventricular rhythm which was converted to ventricular fibrillation. Because of the feeling that external cardiac massage was not adequate, the chest was opened and internal cardiac massage started. Repeated internal defibrillation failed to convert the ventricular fibrillation. Despite all measures, the heart did not respond and the pupils remained fixed and dilated. Two hours after resuscitation was started the patient was pronounced dead.

An autopsy was performed and revealed ruptured left ectopic tubal pregnancy, bilateral fibrous tubo-ovarian adhesions, hemoperitoneum and pulmonary edema.

Case 3

A 23-year-old woman was scheduled for elective tubal sterilization via laparoscope. Two days prior to the planned operation, she was delivered under local anesthesia. Her past history and course of the pregnancy were uneventful.

Anesthesia was induced with sodium thiopental 300mg and the trachea was intubated after succinylcholine 80mg. Anesthesia was maintained with halothane 1% and nitrous oxide 50% using a semi-closed system. Muscular relaxation was achieved with gallamine hydrochloride. A Verres needle was inserted and CO_2 insufflation started. Subcutaneous emphysema was noted over the entire abdomen and thorax and the needle was repositioned. Despite insufflation of approximately 4 liters of CO_2 abdominal distention was inadequate. Blood pressure was stable at 130/80 mmHg and heart rate 82 beats/minute. Suddenly, about 25 minutes following induction of anesthesia, the heart beat disappeared and the blood pressure became unobtainable. Laparoscopy was immediately terminated and the insufflated CO_2 released. External cardiac massage was begun, 10mg phenylephrine and 1mg epinephrine were injected and $NaHCO_3$ drip started IV. The EKG monitor was connected and revealed ventricular fibrillation. Defibrillation resulted in ventricular tachycardia with palpable peripheral pulses. Within a few minutes, ventricular tachycardia spontaneously converted to normal sinus rhythm. Electrolytes and blood gases were within normal limites.

In less than 10 minutes, the patient started to show signs of awakening. Following administration of 5.0mg of neostigmine and 2.4mg of atropine, ventilation became adequate and the patient was extubated. Postoperatively the patient had left hemiparesis which resolved gradually over a period of several days except for

weakness in the left arm.

Case 4

A 32-year-old woman was admitted for investigation of infertility. She had been complaining of pain in the lower quadrant of the abdomen for two weeks.

Physical examination revealed a thin, somewhat dehydrated patient. Blood pressure was 100/70 mmHg, heart rate 82 beats/min. and regular. Pelvic exam showed tenderness in the left lower quandrant of the abdomen and there was a questionable mass in the same area. Chest roentgenogram, electrocardiogram and laboratory findings were within normal limits.

The patient was premedicated with meperidine 50mg and atropine 0.4mg. Preoperative blood pressure was 94/60 mmHg. Anesthesia was induced with sodium thiopental 200mg and endotracheal intubation performed after relaxation with succinylcholine 60mg. Anesthesia was maintained with halothane 1% and nitrous oxide 50%. The patient was placed in the lithotomy and slight Trendelenburg position and prepped and draped in the usual manner. The needle was inserted below the umbilicus and CO_2 insufflation begun. Less than a minute after the start of insufflation of CO_2, the patient started to strain and additional 20mg of succinylcholine was given. Shortly after that it was felt that inspiratory resistance started increasing and it became very difficult to ventilate the patient. Examination of the chest revealed absence of movement and breath sounds on the right side of the chest. In a few seconds the blood pressure became unobtainable. The surgical procedure and anesthetic gases were discontinued and the pneumoperitoneum released. Ephedrine 50mg was given IV after which the blood pressure became obtainable. Chest roentgenogram revealed a complete pneumothorax on the right side. A 20mg needle was inserted into the right second intercostal space and approximately 1000ml of the air aspirated. A chest tube was inserted and recovery was uneventful. The patient was discharged on the ninth postoperative day.

Discussion

It is generally agreed that the mortality rate associated with laparoscopy is low. Horwitz[8] reviewed the literature covering 35,000 cases and found an overall mortality rate of approximately 0.2%. Previously mortality rates had been much higher, but most recent studies indicate mortality rates of almost zero. Despite this encouraging trend, sporadic incidences of cardiac arrest indicate possible hazards of the procedure.

Although the laparoscopy can be performed under local anesthesia and sedation, the preference of both patient and surgeon is usually for general anesthesia, especially if biopsy or diathermy are to be performed. A steep Trendelenburg position and high intraabdominal pressure can produce respiratory embarressment and it is important the ventilation be supported. The combination of a head-down position and increased intraabdominal pressure can precipitate emptying of the stomach and thus increase the possibility of aspiration. The need for ventilatory support and the increased possibility of aspiration are in our opinion strong indications for endotracheal intubation. In Case 2, hypoxia could have been a factor leading to severe bradycardia and cardiac arrest, and in our opinion the presence of an endotracheal tube would have minimized that possibility and made resuscitation easier.

Increases in arterial carbon dioxide tension during laparoscopy using carbon dioxide insufflation has been well documented by several investigators.[1,2,6] Alexander[9] showed that the increase in arterial PCO_2 is primarily due to the diffusion of carbon dioxide from the abdominal cavity. Since the increase in carbon dioxide tension decreases the arrhythmia threshold during halothane, hypercarbia may induce ventricular arrhythmias during halothane anesthesia.[10] The occurence of ventricular arrhythmias during laparoscopy has been associated with pronounced increase in arterial carbon dioxide tension.[1,12] Since frequent ventricular arrhythmias are considered to be "pre-fibrillatory," EKG monitoring during laparoscopy is essential.

Alexander[1] noticed that the pulse pressure decreased during laparoscopy and postulated that the combination of increased intraabdominal and intrathoracal pressure may cause a decrease in cardiac output. Desmond and Gordon[6] proposed that increased intraabdominal pressure would produce a decrease in venous return to the heart and as in the supine hypotensive syndrome, it could produce a decrease in cardiac output. Contrary to this, other investigators observed increases in central venous pressure (CVP) after moderate elevation of intraabdominal pressure.[3,11] It is possible that moderate increases in intraabdominal pressure might force blood from the abdominal viscera to the thorax and in this way produce a temporary increase in central venous pressure. Hodgson et al[12] ex-

pressed the opinion that the increase in CVP during laparoscopy is mainly due to enhanced sympathetic activity produced by increased arterial carbon dioxide. However, Motew and associates[11] observed that increases in intraabdominal pressure over 20-25 mmHg will produce a decrease in CVP which was sometimes quite precipitous; thus, it is possible that higher intraabdominal pressures produce occlusion of the inferior vena cava.

It is conceivable that the high intraabdominal pressures, used not so infrequently in everyday practice, could produce clinical conditions almost identical to the supine hypotensive syndrome. Since intraabdominal pressures higher than 20 mmHg are generally not needed for good intraabdominal visualization they should be avoided. Obviously, continuous monitoring of intraabdominal pressure is of the greatest importance. The use of the newer insufflators (WISAP, APR) will minimize the possibility of an accidental over-insufflation of the peritoneal cavity. A homemade apparatus was used in all of the cases presented here (carbon dioxide tank with shutoff valve, gauge, flowmeter and manometer). The absence of a reducing valve, the lack of careful monitoring of intraabdominal pressures, and a high insufflation pressure are factors that cannot be ruled out in the reported cases. Cohen has stated that most of the complications of laparoscopy occur during the induction of pneumoperitoneum and that it is important to carefully watch the insufflation pressure. If a homemade apparatus is used, the addition of a "pop-off" valve can prevent unexpected increases in intraabdominal pressure.[13] If an automatic apparatus is not available, such an addition may decrease the possibility of abdominal over-insufflation.

Horwitz[8] has collected from the literature several cases of air embolism following the production of pneumoperitoneum with air. Carbon dioxide, because of its high solubility in the blood, is unlikely to produce serious embolic phenomena and is therefore recommended for intraabdominal insufflation. In support of this, Oppenheimer and associates[14] found that carbon dioxide embolization is well tolerated physiologically and suggested that gas be used for intracardiac diagnostic procedures. However, Kunkler[15] has demonstrated in animals that fatal carbon dioxide embolization is possible. He found that 5.3 times more carbon dioxide than air is needed to produce a fatal outcome. According to Horwitz,[8] the introduction of carbon dioxide at the rate of 1 liter/minute (the usual rate of CO_2 insufflation) will inevitably produce a serious embolization if accidentally introduced into a vessel. Despite this possibility, neither ventricular fibrillation or signs of cerebral damage have previously been reported following peritoneal insufflation with carbon dioxide. In Case 3 massive retrograde carbon dioxide embolization of coronary and carotid arteries is the most likely cause of ventricular fibrillation and hemiparesis. In 20 to 25% of adults the foramen ovale is functionally but not automatically closed. The increased pulmonary resistance during air embolization would allow gas to shunt directly from the right to left atrium, thus into the systemic circulation.[16]

Subcutaneous emphysema, probably the most frequent complication, is usually the result of faulty placement of the needle. However, with the use of carbon dioxide, absorption is so rapid that this rarely presents a problem. The escape of gas may also occur into the mediastinum and can sometimes produce pneumothorax. Several cases of pneumothorax have been reported in the literature, and in all cases air was used to produce pneumoperitoneum. According to Riegel,[17] pneumothorax during laparoscopy can develop because of anomalies with dehiscences in the diaphragm, pathologic conditions such as tuberculosis of the diaphragm and increased abdominal pressure associated with pulmonary emphysema. In our opinion, the production of very high intraabdominal pressures is probably the most important factor in causing pneumothorax. If gas is introduced into the retroperitoneal space under high pressure, it can escape through the mediastinum and produce pneumothorax. A high intraabdominal pressure combined with a headdown position will necessitate much higher inspiratory pressure if ventilation is assisted or controlled.[1] High inspiratory pressure, in the presence of pulmonary emphysema or congential emphysematous cysts may produce tension pneumothorax.

Although it is generally agreed that mortality and morbidity associated with laparoscopy is very low, the reported cases of cardiovascular collapse and cardiac arrest indicate possible hazards of the procedure. Proper monitoring of patients and avoidance of high intraabdominal pressure can further decrease the incidence of possible complications. It would be most unfortunate if this useful procedure fell into disrepute owing to the occurrence of avoidable tragedies. ◄

(Continued on page 77)

History of Medicine

Marcus P. Hatfield— The First Pediatrician at Northwestern

By Ronald D. Greenwood, M.D./Boston



Marcus P. Hatfield, M.D.
Reproduced with permission of the Northwestern University Medical School Library.

The Department of Pediatrics did not exist in the original framework of the medical school that was to become Northwestern University Medical School. The medical school founded in 1859 existed as the Medical Department of Lind University from 1859 to 1863, as The Chicago Medical College from 1863-1870, and then as Chicago Medical College, The Medical Department of Northwestern University from 1870-1891. It was not until 1891 that the ties were made stronger and the school became Northwestern University Medical School still retaining its own charter and the right to retain the name Chicago Medical College in brackets. In 1906, the charter was surrendered and the medical school became an integral part of Northwestern University.

The discipline of pediatrics was included in the chair of Obstetrics and Diseases of Women and Children. The first occupant of that chair was William H. Byford, an eminent gynecologist, who began his tenure in 1859 as one of the founders of the school and resigned in 1879 to accept the position in gynecology at Rush Medical College. The second professor was Edward O. F. Roler, who was Professor of Obstetrics and Diseases of Women and Children from 1870 to 1883. At this time separate disciplines were formed and he went to Obstetrics. A third professor was Edward W. Jenks, whose term at the medical school was shortlived. Jenks was hired in 1879 to fill the chair of Obstetrics and Diseases of Women and Children. On his acceptance, the chair was divided into two chairs—one for Obstetrics and Children and one to be known as Medical and Surgical Diseases of Women and Clinical Gynecology. Roler filled the former, Jenks the latter. Jenks resigned in 1883.

The combined discipline of Obstetrics, Disease of Women and Children was chaired by the two or three (depending upon how precise you wish to be) professors mentioned although others shared in the classroom and dispensary teaching.

However, pediatrics really began in 1883 with the first professor of pediatrics, Marcus P. Hatfield—although there was no official Department of Pediatrics until 1896. Hatfield was the first chairman of the new department and remained until 1899. The later chairmen were Francis X. Walls 1901-1909, Issac A. Abt 1909-1939, W. Stanley Gibson 1939-1948, John A. Bigler 1949-1962, Robert B. Lawson 1962-1971, and Henry L. Nadler from 1971 to the present time.

Marcus, the son of a Methodist minister, Robert M. Hatfield, was born in New York City on February 20, 1849. He began his college studies in the University of Chicago. In 1870, Hatfield entered the Chicago Medical College from which he graduated in 1872, ranking high in his class. He interned at Mercy Hospital, and he studied in Europe in 1873-74, at Berlin, Vienna, Zurich and London, with such men as Henock, Bardelehen, Frerichs, and B. von Langenbeck.

He then returned to Chicago and entered the practice of medicine, and from 1875 to 1882 was Professor of Chemistry at Northwestern University Medical School. From 1881 to 1883 he was also Professor of Medical Jurisprudence. From 1883 to 1899 he was Professor of Pediatrics, and during the years 1893-99, was chairman of that department.

During this professional career, he was associated with Dr. I. Danforth "in the work of setting Wesley Hospital on its legs, and helping to tide it over its callow days." In addition to being a founder, Hatfield was also secretary and member of the medical board, secretary and member of the executive committee at that institution.

In his earlier years of "professorship," he lectured on inorganic chemistry, toxicology and medical jurisprudence. Lecture notes taken by two of his students in the 1881-82 year are preserved in the Northwestern University Medical School Library (notes by G. E. Wire and N. S. Davis). The toxicology course included a discussion of the topics: cyanogen, phosphorus, phenol, lead, silver, mercury, copper, bismuth, arsenic, antimony, zinc, iron, and potassium. The Medical Jurisprudence series included the topics: pregnancy, abortion, sign of recent confinement, post mortem sign of confinement, size of fetus at different periods, hydatids, infanticide, blood stains, and the decision of death and rape. On the subject of death, Hatfield instructed his students:

> After death, action of heart and lungs have been suspended for various times. Postmortem changes are noticeable after a few hours. Sealing wax on chest muscles and a piece of paper will indicate breathing. A hypodermic injection in a living body will cause purplish stain and none in a corpse. Heat or ammonia will not blister the skin of a corpse. Heat of the body will not be lost for three to four hours. Rigor mortis begins at the head and spreads downward and lasts from 16-24 hours. Putrefaction starts in the umbilicus and spreads, next in the larynx and lower jaw. Heart, lungs and uterus retain structure longest of the soft tissues and the uterus longest of all soft tissue in the entire body.

His writings include a section in a pharmaceutical, anatomical and chemical lexicon entitled The National Funeral Director's Association of the U.S. in 1886, Practical Urinalysis, The Physiology and Hygiene of the House in Which We Live in 1887, A Compend of Diseases of Children Especially Adapted for the use of Medical Students which underwent three edition—1890,

RONALD D. GREENWOOD, M.D., a former resident at Children's Memorial Haspital, Chicago, is with the Department af Cardiology at Children's Haspital Medical Center, Boston.

1896, and 1903, The Acute Contagious Diseases of Children in 1901. And, he assisted Dr. I. N. Danforth in the first chapter of his The Origin and Early Years of Wesley Memorial Hospital in 1909.

The Compend of the Diseases of Children was a text founded upon by Dr. Ernst Kormann's Compendium der Kinderkrankheiten translated by Hatfield and E. J. Doering while fellow students at the University of Berlin. This, then, became the basis of an annual lecture series at Chicago Medical College and finally resulted in the text. It is thorough; and the 1903 edition covers anatomy and physiology, the physiological and traumatic accidents of birth, early ailments and dietetics of the infant, diseases of malnutrition, epidemic and endemic infectious diseases, diseases of the nervous system, respiratory and circulatory organs, mouth, throat and digestive apparatus.

The discussions of diseases are interesting. For example, let us consider "blue babies." Hatfield calls the disease Cyanosis Infantum with synonyms Morbus Ceruleus and the Blue Disease.

> Strictly speaking, not a disease at all, but an almost invariable symptom of any disease attended with defective oxygenation of the blood. Of special importance in early life as indicating cardiac malformation, though it should be remembered that this may exist without cyanosis. "White Cyanosis" is the name given by Mouls to such cases. Morbus Winckelii is the name given to an epidemic form of cyanosis first fully described by Winckel in 1879; as observed by him in the Dresden Hospital. Some sporadic cases had previously been reported by Garrod, Begelow and Baginsky.
>
> Once supposed to be due to malevolent spirits. In more than half of the cases, examined after death, malformation have been found in the pulmonary artery. Others arise from the mixing of arterial and venous blood in the heart, from a patent foramen ovale or other congenital defect; and others, according to J. Lewis Smith, are due to a congenital failure of oxygenation of the blood without recognizable lesions. No accurate chemical examination of the blood of cyanotic children has yet been made, but it probably closely resembles ordinary venous blood. The liver is usually large and congested; pericardial and pleuritic effusions are frequent occurences. More frequent with males than females and increases with bulk of population. Often hereditary in families, but even when due to congenital malformation, symptoms not necessarily occur immediately after birth.
>
> Symptoms are chiefly those of blueness or lividity of the face, lips, and tips of the fingers, intensified by exertion or fright, which occasion paroxyms of dyspnea. Clubbing of the fingertips found in all chronic cases. Prognosis—unfavorable for recovery, though not immediately fatal, for life may be prolonged for years. Eighty percent die in the first five years. Very bad in Winckely's Disease.
>
> Treatment—rest, mental and physical, digitalis, quebracho and chlorate of potash and tonics.

The Acute Contagious Diseases of Children was written when Hatfield was Emeritus Professor and included discussion of eight diseases—scarlatina, measles, Rothelu or German Measles, parotitis epidemica, pertussis, varicella, variola, and LaGrippe.

Hatfield was Assistant Editor of *Archives of Pediatrics;* a member of the American Medical Association and American Academy of Medicine, and the section on diseases of children at the Ninth International Medical Congress. He organized the Chicago Health Department in 1867 and St. Luke's Hospital in 1864. He was chosen as secretary of the committee that disbursed the Chicago medical relief fund for fire sufferers after the fire of 1871. He was President of the Chicago Pediatric Society in 1902-03.

On the morning of November 11, 1909, Dr. Hatfield died at Wesley Hospital after an illness of several months duration.

Drs. Danforth and Hatfield had made an agreement, "half in earnest, half in jest" that the survivor of the two should write a tribute to the other. Danforth did that, and it was published in the *Northwestern Christian Advocate* of December 1, 1909, and recounted again in his History of Wesley Hospital. He describes Dr. Hatfield in the following passages.

> I found him one of the most persistent, resourceful, and capable men that I was ever associated with. But I need not spend any time recounting his various professional positions of honor, or dilating upon his well known merits as an eminent and skillful physician, particularly as a specialist in diseases of children—a department of medicine in which he was singularly gifted, both as a practitioner and professor. But I wish to say a few words about Dr. Hatfield as a man. It needs no long-drawn jumble of words to characterize the manhood of Marcus Patten Hatfield. He was not very self-assertive; in fact, he was rather too modest for his own good; he had to be "found out" by intimate and daily association; he never blew his own trumpet. But, he was true as the needle to the pole to any cause he espoused, and his loyalty to his personal friends was proverbial. It sounds silly to say that he was honest—it was impossible for him to be otherwise. As we down-East Yankees were accustomed to say to a man of a straight-forward honesty, he "would staind without hitching."
>
> Dr. Hatfield's convictions were a part of himself; not something that he could put on and take off, like his coat or his hat, and he could stand up for his opinions vigorously and incisively if occasion demanded. He was a master of sarcasm and invective, and these weapons, like the old Springfield flintlock muskets, are likely to "kick-back," and do their chief damage to the one who "fires" them, and sometimes my friend Hatfield's tongue left stings behind, which festered and rankled longer than he intended. But all this was indigenous to the soil, and was only an illustration of its productive possibilities. But it is not necessary to multiply words. Hatfield's earthly record is closed, and it will grow brighter as the perspective of time and distance are thrown upon it.

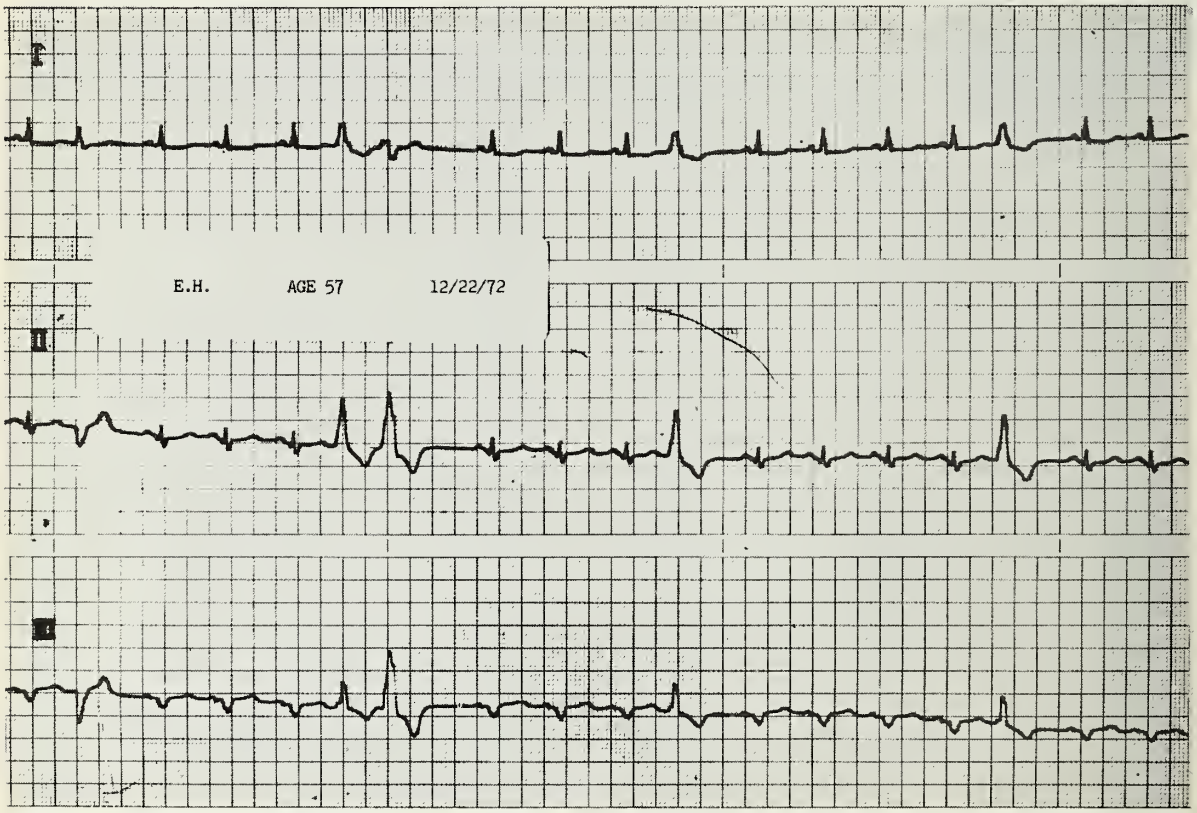
The choice of a successor to Hatfield was a difficult decision and one of great historical importance. In 1896, Isaac A. Abt (1867-1955) had become an instructor at Northwestern and had begun to show his importance. Abt felt his appointment as Hatfield's successor was eminent and deservedly so. However, the Dean at that time, Nathan Smith Davis, Jr., appointed Francis X. Walls as the second professor of pediatrics. Dr. Walls was an old friend and school roommate of Abt.

Walls was a man of ability, but he had no particular training in pediatrics and had previously engaged in teaching pathology, surgery and internal medicine. Abt inquired as to why he had been passed over. Davis did not explain why but merely told Abt that he could go just as far in his private practice as he could as a professor. Dr. Archibald Church, however, gave Abt a reason. Abt had been charged with favoring certain students who belonged to his medical fraternity. This was most upsetting for Abt had no idea of his student's affiliations and was not active in his fraternity. Abt felt this was "a little short of tragedy." For Northwestern Medical School, it was not that, it was a tragedy. And, had it not been for an ironic turn of events a few years later, the leadership of pediatrics in Chicago and the country would most likely have been elsewhere, and the rich heritage that Northwestern enjoys would have been thrown away by a few short-sighted

(Continued on page 79)

ekg of the month

John R. Tobin, M.D., M.S., Rimgaudas, Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., James V. Talano, M.D., Sarah Johnson, M.D. and Rolf M. Gunnar, M.D., M.S./Section of Cardiology, Loyola University Stritch School of Medicine



This patient is a 57-year-old man who had an inferior wall myocardial infarction five years ago. Two years ago he developed angina pectoris, and in the past month this has grown worse. He is having angina more often with lesser exertion and is using more sublingual nitroglycerin. He also admits to occasional extrasystoles. The physical examination was significant for an atrial gallop and premature beats. A lead I, II, III rhythm stip is shown. The diagnosis of inferior wall myocardial infarction was made on the basis of the Q waves in leads III and avF (not shown).

Questions:

1. The ECG shows:
- A. Sinus rhythm
- B. Isolated premature ventricular beats
- C. Multifocal ventricular premature beats
- D. A pair of ventricular beats
- E. All of the above

2. The treatment should include among other things:
- A. Only careful observation at this time
- B. A demand pacemaker
- C. Quinidine or Pronestyl
- D. None of the above

(Answer on page 71)

In Syphilis

Injection

BICILLIN® Long-Acting (sterile benzathine penicillin G suspension) Wyeth

Benzathine penicillin G...a drug of choice recommended by the national Center for Disease Control in all stages of syphilis and in preventive treatment after exposure.

Administration of 2.4 million units (1.2 million in each buttock) of benzathine penicillin G usually • cures most cases of primary, secondary and latent syphilis with negative spinal fluid • helps break chain of infection • minimizes chance of immediate reinfection.

Indications: In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms including fungi. Take appropriate measures should superinfection occur.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

Congenital—under 2 years of age, 50,000 units/Kg. body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

(Shake multiple-dose vial vigorously before withdrawing the desired dose.) Administer by **deep intramuscular injection** in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

Composition: 2,400,000 units in 4-cc. single dose disposable syringe. Each TUBEX disposable syringe also contains in aqueous suspension with sodium citrate buffer, as w/v approximately 0.5% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. Units benzathine penicillin G (as active ingredient); 300,000 units per cc.—10-cc. multi-dose vial. Each cc. also contains sodium citrate buffer, approximately 6 mg. lecithin, 3 mg. polyvinylpyrrolidone, 1 mg. carboxymethylcellulose, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Wyeth Laboratories · Philadelphia, Pa. 19101



surgical grand rounds

Edited By John M. Beal, M.D.

Tuberculosis of Kidney

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion. Patient presentations from the Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of July 24, 1973.

Dr. Ronald Sadlowski: A 51-year-old white man, born in the Ukraine, came to this country at the age of 28 and worked as a pipe-fitter. He was admitted to Passavant Pavilion on June 20, 1973. Ten days before admission he was awakened with an urge to void at 2:00 a.m. and noticed gross total hematuria. He developed urinary retention and was hospitalized promptly. Catheterization was required for relief of his retention and the urine cleared promptly on catheter drainage. The patient reported a six month history of nocturia times three with hourly daytime frequency of moderate urgency and associated with dysuria. He stated he had good force and caliber of his stream and denied fever, malaise, flank pain, or weight loss. He was evaluated at another hospital for renal tuberculosis. Urine specimens were obtained for acid fast bacilli and were positive on the smears. A work-up was initiated and an IVP was obtained and cystoscopy and retrograde studies were obtained.

Dr. Harold Matthies: The films made elsewhere in June show calcification in the lower pole of the right kidney. There was no calcification seen in the left kidney and both kidney shadows are nicely delineated. No calcium is seen in the seminal vesicles, the adrenals or the vas deferens. On the examination made elsewhere we see good visualization on both sides. The calyces are irregular on the right but the inflammatory changes in the calyces are much better demonstrated on the retrograde examination made elsewhere. (Figure 1) Subsequent excretory urography done here at the Passavant Pavilion fail to show any diagnostic opacification of the collecting system on the right; there was, however, a satisfactory nephrogram on the right. The left kidney, again, is normal in appearance without evidence of calcification or inflammatory change in the calyces. A nephrotomogram was subsequently done and again no visualization was seen in the right kidney in rather striking contrast to the films made elsewhere in June. (Figure 2) The findings then are those of inflammatory change in kidney with calcification and renal tuberculosis is one of the first considerations.



Figure 1. Retrograde pyelogram demonstrates irregularity of calyces of right kidney.



Figure 2. The left kidney has normal appearance with nephrotomography but the right kidney is not visualized.

Dr. Ronald Sadlowski: After cystoscopic and retrograde examination, he developed malaise, fever with spiking temperatures to 102° F. daily. He was then transferred to Passavant. When admitted, he was a chronically ill appearing man. Pertinent physical findings included a questionable mass in the upper right quadrant. A 1 cm diameter area of mild duration was present in the prostate gland and otherwise his physical examination was unremarkable.

At this time he revealed that he was hospitalized 16 years earlier with a right renal infection of one month's duration, thought to be a bacterial infection. The laboratory data at the time of admission included a urinalysis showing 4 to 6 red cells with an occasional white cell. Expressed prostatic fluid revealed numerous red blood cells with one to two white cells. The creatinine clearance was 120 cc a minute, BUN was 17 mgm%. Urine smear and culture for tuberculosis were positive. Routine urine and blood cultures were obtained which revealed no growth. Hemoglobin was 13.5, hematocrit 39, white count 14,000 with 78 segmented forms and 14 lymphocytes. A renogram revealed absence of function on the right and normal function on the left. Cystoscopy revealed a diffusely hyperpyremic bladder with a refracted right ureter and marked inflammation immediately around the right ureteral orifice. Yellowish-white debris was seen coming from the right ureteral orifice. An unsuccessful attempt was made to catheterize this right ureteral orifice. Chemotherapy was initiated. Streptomycin 1 gm, INH 300 mg and anthamuthol 1200 mg daily. However, the spiking fever progressed and the patient continued to appear ill. Therefore, a right nephrectomy was performed June 28th.

Dr. Hector Battifora: Anytime there is a specimen in pathology with a diagnosis of tuberculosis, no one wants to touch it and certainly no one wants to photograph it. I am presenting that preamble as an excuse for not having a gross photograph of the kidney. The kidney was full of abscesses. There was a moderate degree of hydronephrosis and a hydroureter with a stenotic zone distally. The abscesses appear as slit-like cavities containing necrotic material surrounded by a lot of inflammatory cells. Their walls contained occasional typical Langhans giant cells. Small granulomas were seen elsewhere in the parenchyma of the kidney as well as in the wall of the renal pelvis and ureter. (Figure 3) Sections stained with the Ziehl-Neelsen and Auramire stains were both positive for organisms which are considered to be compatible with tuberculosis. The pathologic diagnosis is, then, renal and ureteral tuberculosis.

Dr. William Buckingham: The last surgical rounds that I attended was also about two cases of renal tuberculosis more than a year ago. This is a fairly common problem and one of which you're going to see more. Renal tuberculosis as well as bone and joint tuberculosis occur as last complications of the initial primary infection. A primary infection from an inhaled source of pulmonary tuberculosis developed and this was successfully handled, but part of the post-primary spread was to the renal area. The first manifestation of renal tuberculosis was the right renal infection 16 years ago. The nature of this disease is that it will spontaneously exacerbate and regress without treatment. This case is a little different in that it required surgical intervention. The man was very ill and he was not showing

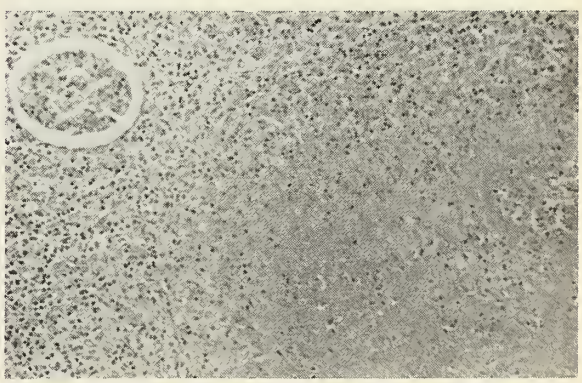


Figure 3. Microscopic examination demonstrates zone of caseation necrosis in renal cortex. Note the well preserved glomerulus in the corner of the photomicrograph.

any improvement with the chemotherapy. I wonder if the acute flareup of the symptoms didn't have something to do with the instrumentation of inserting the retrograde catheters into the area of the infection. If you notice on the intravenous pyelogram taken elsewhere, there was dye appearing in the collecting system. Even on the tomogram taken here there is no dye appearing. Between the two pyelograms, a complete occlusion of the collecting system developed. This was followed by the systemic effects of the infection. The way to treat renal tuberculosis is the same as any tuberculosis, which is with chemotherapy.

Ordinarily, there are no reasons for surgical intervention for pulmonary tuberculosis, bone tuberculosis, or renal tuberculosis. In this case, the surgical intervention was required because of the mechanical blockage and flareup of the infection following instrumentation. I just want to say a quick word about how treatment has changed. It is probably more effective to give the drugs all at once in the morning. That is, usually 300 ml of INH and 800 to 1200 mg of ethambutal. PAS has been pretty much dropped as a drug for use in modern chemotherapy. Streptomycin is still a good useful drug. A new and useful chemotherapeutic agent is rifanpin.

Dr. Earl Wendel: A thorough discussion of renal tuberculosis is not feasible in the time limitations of this conference. In the following remarks, I will attempt to review certain important aspects of the case that was presented. In reality, the patient did not present the orderly sequence of events that was described, but was transferred from another hospital when he became acutely ill. His X-rays and laboratory tests came later. The tentative diagnosis at the other hospital was a possible renal neoplasm, although tuberculosis was considered.

When the patient's history was reduced to essential facts, it was noted that he was a robust middle-aged man who had a six month history of change in his voiding pattern with increased urinary frequency day and night, urgency, and mild burning with urination. Then he had the sudden onset of gross total hematuria with clots, developed urinary retention secondary to the blood clots and was admitted to another hospital. After initial therapy, an intravenous pyelogram was performed and revealed calcification in the lower pole of the right kidney with some irregularity of the calyces, but visualization was rather poor. There was one positive smear for acid-fast bacilli, but this is not diagnostic. This may represent Mycobacter magentis, a tap-water bacillus, rather than tuberculosis. After cystoscopy and retrograde pyelography, the patient became acutely ill and was transferred to our institution with temperature of 103-105° F.

We obtained additional urine collections for culture for tuberculosis on the basis of his intravenous pyelograms. When the retrograde studies became available and were reviewed, we felt that renal tuberculosis was the most likely diagnosis. After the urine cultures were obtained, antituberculosis therapy was instituted. consisting of Streptomycin, Isoniazid and Ethambutal. Keflex was administered as well because it was felt that he had a secondary infection of the kidney following the cystoscopic examination. Despite this intensive therapy, he did not improve after a week of observation and continued daily febrile episodes to 105° F. It seemed probable that his ureter was obstructed, secondary to inflammation and instrumentation. Therefore, cystoscopy was repeated. At this time, the typical changes of tuberculosis were found in the bladder with tubercles and a retracted "golf-hole" ureteral orifice on the right side. Efforts to pass ureteral catheters to relieve the obstruction failed. This finding combined with the lack of function on intravenous pyelography and renograms led to the conclusion that nephrectomy was indicated.

When operation was undertaken, the right ureter was found to be markedly thickened and stiff. The lower end of the ureter was drained to the skin because it was not technically feasible to remove it below the level of the pelvic brim without seriously increasing the risk to the acutely ill patient.

For those interested in reading about renal tuberculosis, the best description of the disease and its manifestations are to be found in the medical literature before 1940. Streptomycin was developed around 1944 and other chemotherapeutic agents have appeared subsequently. However, the literature before 1940 is more interesting in regard to the progression of the disease and its surgical treatment. Approximately 70-80% of patients with renal tuberculosis are between the ages of 20 and 50 years and men are affected more often than women. It is uncommon in children. Only six of 1082 patients in one series were under the age of 11 years. This is accounted for by the finding that it requires two to 20 years for the development of the disease from the time of the initial

infection. It is a chronic, progressive disease without symptoms, until the bladder becomes involved. Then lower urinary tract inflammatory symptoms ensue with increased frequency of urination, urgency and burning with voiding. Sterile pyuria, persistent pyuria with antibiotic treatment, or painless hematuria are signs that may alert the physician to the possible presence of renal tuberculosis.

Surgical treatment is probably indicated in the end stages of the disease, for the so-called "putty kidney" or "mortar kidney" where there is calcification, absence of function and persistent pyuria. Other indications include progression of the disease process while receiving adequate chemotherapy, or complete obstruction of the ureter with pyelonephritis or pyonephrosis above the obstruction, as in this patient.

Dr. John Grayhack: Dr. Wendel made a good point concerning the asymptomatic nature of this disease over a long period of time. Whenever you see calcification in the kidney, you ought to think seriously about the patient having tuberculosis. There are few diseases that produce calcification in the kidney. ◄

EKG of the Month

(Continued from page 64)

Answers: 1. E 2. C

The ECG shows basically sinus rhythm with frequent premature ventricular beats (PVBs), occasionally multifocal on in a pair. There is nothing to suggest these beats are supraventricular in origin. This patient had proven coronary artery disease on the basis of an old myocardial infarction and angina pectoris. PVBs are not diagnostic of coronary artery disease, but in the presence of proven coronary artery disease PVBs often are associated with severe obstructions of the coronary vessels and often left ventricular dysfunction. Some authors feel they represent a manifestation of subclinical ischemia if seen in patients with coronary artery disease in exercise. Therefore, suppressant therapy with quinidine or pronestyl is indicated. ◄

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

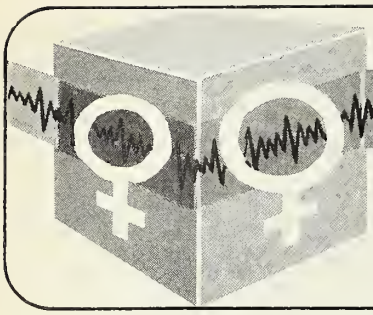
CHICAGO AREA OFFICE:

T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives

815 Cammerce Drive, Suite 102, Oak Braak, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative

426½ Sauth Fifth Street, Springfield 62701 (217) 544-2251



pulse... of the doctor's wife

Mrs. Rosanne K. Frank, *Editor*

Our Benevolence Fund

The cold winds of winter are this year even more penetrating it seems, because of the energy crisis, but there is a great deal of internal warmth available to us if we remember our friends in need. Physician's families who depend upon our own Benevolence Fund for support this year number 21 widows and four physicians. County medical auxiliaries have been most generous in the past, and we hope they will continue to assist those who find themselves unexpectedly in financial need.

Misfortune may come to any of us; the best laid plans for security in old age often go to pieces when investments turn out badly, or one lives beyond normal life expectancies. The benevolence fund was started as a non-governmental cushion against such disaster in 1940. In Illinois there is an average payment of $5,000 per month for this purpose; name of beneficiaries are a closely guarded secret.

Your contributions can be your way of saying: "In thankfulness for my good fortune let me help those who need it more than I do." Contributions should be sent to your county President or Benevolence Chairman.

Your auxiliary can raise funds, by planning activities to ease the winter doldrums. There is always the bridge party. Open house events are successful fund raisers. Theater parties. No two auxiliaries do the same thing, and here is an opportunity to exercise your creativity. Some donate directly from the treasury. The end result is what counts: how much each county is willing to contribute.

Mrs. Robert (Meinard) Kooiker, Benevolence Chairman

From The President's Desk . . .

We have reached a turning point in our year. We are turning past the final obstacles in our year's journey, and rounding the few remaining curves, taking us toward successful achievement. Those of us who have been working assiduously since our March, 1973, convention, have already been "in training," and have profited in our learning experiences. Those of us who are completing unexpired terms, or who have just come into office as new county presidents, officers and chairmen, are fortunate in that opportunities for educating themselves for their jobs have occurred in the past, and others lie ahead for their future enlightenment. We need to prepare ourselves for responsibility by reading, listening, thinking, and striving to avail ourselves of every resource. For me, during the holiday season, it wasn't "visions of sugar plums which danced in my head," but visions of our April convention which filled my dreams. We have excellent chairmen, a wonderful program, and important business to conduct, as we adventure with the stars on April 3, 4 and 5. At a convention-planning meeting on Nov. 30, it was decided to eliminate the Saturday sessions; so Saturday, April 6, will be free for shopping.

The Convention Flyer will be mailed to the membership at the end of January, but in the meantime, please put a STAR over April 3, 4 and 5, and plan to attend, with as many of your county auxilians as you can get together. Wednesday afternoon, April 3 will be a delegate session, Thursday morning will feature our National President, Mrs. Willard C. Scrivner, followed by the Presidents' luncheon, honoring Mrs. Scrivner, Past Presidents, and County Presidents and featuring a style show by Lord and Taylor. Thursday afternoon will require delegate voting, and Friday will feature informative speakers, county reports, the Installation Luncheon, and a leadership course for everyone in the afternoon.

We look forward to seeing all our stars at all convention functions.

Mrs. Robert (Bea) Hartman
WA/ISMS President

Editor's Note . . .

As your editor, and fellow auxilian, I extend my warmest wishes to all for a joyous and happy new year.

Rosanne K. Frank,
Editor

Activities of Winnebago County

Winnebago County, once again, is proving that they have some very active auxilians in MICKEY GLATTER'S back yard. **Pat Hagman,** County President, sent us a four page news-letter which should be shared with people at convention, and which is an example of what can be done. Some news items from Winnebago County are:

- They have organized a Volunteers Service Program to work with the Public Health Nursing Dept. Two women will be working with the Family Planning Clinic; three have been trained to do the Denver Developmental Testing for screening of pre-school children.
- They organized a tour of their new medical school, with a luncheon following. Whether one has a new medical school, or an old one, what a marvelous way to get acquainted with what is REALLY GOING ON in medical education. So often we are expected to be knowledgeable, and when faced with critics of the total health education effort find ourselves put to a hard task to come up with factual rebuttals.
- Members of the auxiliary whose dues are PAID UP are automatically members of the ROCKFORD NURSING FOUNDATION. That means truly complete involvement in community affairs, as an identifiable body of women.

News Briefs

Mrs. Willard C. Scrivner, our national auxiliary President, reminds us: "It behooves us to present a united front to medicine's political critics. We do not have the time, nor can we afford Prima Donnas or Splinter Groups if we are to maintain effective leadership in protecting and improving the health of our fellow citizens. Remember the banana that leaves the bunch gets skinned."

* * *

Lead Poisoning is getting more attention. It is long time overdue, of course, because the full impact of long-time permanent effects is just coming to public awareness. To facilitate educational efforts for combatting this scourge of the little one's, who need our protection, is a new publication which might be widely disseminated by auxiliaries.

"The Flake and His Secret Plan" is a comic book put out by the government. Send 30¢ for each copy, #HE 20.2852:5-39R, Public Documents Distribution Center, Pueblo, Colorado 81009.

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
360 No. Michigan Ave. • Chicago, IL 60601 • (312) 782-1654

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

FEBRUARY

Allergy

ALLERGIES: LAB TESTS

For: Family Physicians. Feb. 21, 1974, North Hospital, Wausau, Wis.

Hrs. of Instr.: 4. **CME Credit:** AAFP. **Fee:** $10.

Sponsor, contact: Dept. of Continuing Medical Education, Univ. of Wisconsin, Rm. 560, WARF Bldg., 610 N. Walnut St., Madison, Wis. 53706.

Cancer

TUTORAL ON NEOPLASTIC HEMATOPATHOLOGY

5-day conference, Feb. 4-8, 1974, Center for Continuing Education, University of Chicago, Chicago.

Hrs. of Instr.: 35. **CME Credit:** AMA Category 1. **Fee:** $400.

Sponsor, contact: Univ. of Chicago, Center for Cont. Educ., 1307 E. 60th St., Chicago, IL 60637.

Cardiovascular Disease

SEMINAR FOR PHYSICIANS: "MITRAL INSUFFICIENCY"

For: All physicians. Feb. 6, 1974, Mercy Hospital Medical Center, Chicago, Ill.

Hrs. of Instr.: 6.

Sponsor, contact: Chicago Heart Assn., 22 W. Madison Ave., Chicago, IL 60602.

Emergency Care

MEDICAL EMERGENCIES

For: All physicians. Frontiers of Medicine lecture, Feb. 13, 1974, 2 p.m., Billings Hospital, Chicago, Ill.

Hrs. of Instr.: 3½. **CME Credit:** AAFP, AMA Category 1. **Fee:** $15.

Sponsor, contact: Frontiers of Medicine, Univ. of Chicago, Box 451, 950 E. 59th St., Chicago, IL 60637.

HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA

For: All physicians. Monthly clinical program, Feb. 19, 1974, 8 p.m., Cook County Hospital, Chicago, Ill.

Hrs. of Instr.: 2. **Fee:** none.

Sponsor: Chicago Committee on Trauma, American College of Surgeons. **Contact:** Howard Schneider, M.D., 238 W. 154th St., Harvey, IL 60426.

EMERGENCY CARE

For: Family Physicians, Surgeons, Internists, Cardiologists. 1½-day seminar, Feb. 23-24, 1974, Pfister Hotel, Milwaukee, Wis.

Hrs. of Instr.: 10. **CME Credit:** AAFP.

Sponsor, contact: The Medical College of Wisconsin, 561 N. 15th St., Milwaukee, Wis. 53233.

EMERGENCY MEDICINE

4-day conference, Feb. 26-March 1, 1974, Towsley Center for CME, Univ. of Michigan Med. Center, Ann Arbor, Mich.

Hrs. of Instr.: 28. **CME Credit:** AMA Category 1. **Fee:** $130.

Sponsor, contact: Univ. of Michigan Med. Cntr., Towsley Cntr. for CME, Ann Arbor, MI 48104.

Family Medicine

REFRESHER COURSE FOR THE FAMILY PHYSICIAN

For: Family physicians. 4-day course, Feb. 12-15, 1974, Univ. of Iowa Memorial Union, Iowa City, Iowa.

Hrs. of Instr.: 30. **CME Credit:** AAFP, AMA Category 1. **Fee:** $100.

Sponsor, contact: Univ. of Iowa College of Med., Newton Rd., Iowa City, IA 52242.

MEDICINE FOR TODAY (Spring Series)

For: Family Physicians. Series of correlated lectures, Feb. 28-Mar. 28, 1974, at these cities: Belleville, Berwyn, Centralia, Champaign, Chicago (North, Near West, South West), Elgin, Hinsdale, Kankakee, Melrose Park, Park Ridge, Peoria, Rockford, Rock Island, Springfield.

Hrs. of Instr.: 12. **CME Credit:** AAFP. **Fee:** $45 (members), $50 (non-members). **Regis. Deadline:** Feb. 1, 1974.

Sponsor, contact: Illinois Academy of Family Physicians, 14 E. Jackson Blvd., Suite 1532, Chicago, IL 60604.

Internal Medicine

FRED PRIEBE MEMORIAL SYMPOSIUM ON ARTHRITIS

For: Internists, Family Physicians. Symposium, Feb. 6, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

LIVER DISEASES

For: All physicians. Seminar, lecture. Feb. 15, 1974, 10 a.m., Forkosh Memorial Hospital; Feb. 15, 6 p.m., Lincolnwood Hyatt House; Feb. 16, 10 a.m., Bethany Methodist Hospital, Chicago, Ill.

Hrs. of Instr.: 5. **CME Credit:** AAFP, AMA Category 1. **Fee:** $15 (non-staff, lecture & dinner). **Regis. Deadline:** Feb. 9, 1974.

Sponsor: FAB^3-CME. **Contact:** Mr. S. Plotner, Forkosh Memorial Hospital, 2544 W. Montrose Ave., Chicago, IL 60618; (312) 267-2200.

Pediatrics

THE MEDICAL CARE OF CHILDREN IN DEVELOPED COUNTRIES

For: Pediatricians. Monthly scientific meeting, Feb. 19, 1974, Drake-Oak Brook Hotel, Oak Brook, Ill.

Hrs. of Instr.: 1½. **Fee:** $10 (for dinner); none for lecture. **Reg. Deadline:** Dinner res. in advance.

Sponsor: Chicago Pediatric Society. **Contact:** Bennett Sherman, M.D., 363 Park Ave., Glencoe, IL 60022.

Psychiatry & Neurology

COMBINED PSYCHIATRIC & NEUROLOGIC DISORDERS

For: Psychiatrists, Pediatricians, Neurologists, Family Physicians. Symposium, Feb. 13, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Radiology

LECTURE

For: Radiologists & Residents in Radiology. Feb. 21, 1974, Bismarck Hotel, Chicago, Ill.

Sponsor: Illinois Radiological Society. **Contact:** Raymond L. Del Fava, M.D., Secy., Chicago Radiological Society, St. Francis Hospital, 3355 Ridge Ave., Evanston, IL 60202.

Surgery

FREQUENT SPECIAL SURGICAL PROBLEMS & THEIR MANAGEMENT

5½-day course, Feb. 4-8, 1974, Chicago, Ill.

Hrs. of Instr.: 38½. **CME Credit:** AMA Category 1. **Fee:** $175.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

SPECIALTY REVIEW COURSE IN SURGERY.

For: Surgeons. 2-week course, Feb. 18-March 1, 1974, Chicago, Ill.

Hrs. of Instr.: 99. **CME Credit:** AMA Category 1. **Fee:** $350.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

MARCH

Anesthesiology

WORKSHOP

For: Anesthesiologists. 2-day workshop, March 2-3, 1974, Marriott Motor Hotel, St. Louis, Mo.

Hrs. of Instr.: 16. **CME Credit:** AMA Category 1. **Fee:** $75 (members), $100 (non-members). **Reg. Limit:** 250.

Sponsor, contact: American Soc. of Anesthesiology, 515 Busse Hwy., Park Ridge, IL 60068.

ELECTROCARDIOGRAPHY FOR ANESTHESIOLOGISTS

For: All physicians. 5-day course, March 4-8, 1974, Chicago, Ill.

Hrs. of Instr.: 35. **CME Credit:** AMA Category 1. **Fee:** $150 (approx.). **Reg. Limit:** 35.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING

For: All physicians. 5-day course, March 18-22, 1974, Chicago, Ill.

Hrs. of Instr.: 40. **CME Credit:** AMA Category 1. **Fee:** $250. **Reg. Limit:** 8.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Cancer

DIAGNOSIS & MANAGEMENT OF MAMMARY CANCER

For: All physicians. Frontiers of Medicine lecture, March 13, 1974, 2 p.m., Billings Hospital, Chicago.

Hrs. of Instr.: 3. **CME Credit:** AAFP, AMA Category 1. **Fee:** $15.

Sponsor, contact: Frontiers of Medicine, Univ. of Chicago, Box 451, 950 E. 59th St., Chicago, IL 60637.

MARCH, cont.

Cardiovascular Disease

PATHOLOGY OF THE HEART

For: All physicians. 2½-day conference, March 21-23, 1974, Palmer House, Chicago, Ill.

Hrs. of Instr.: 20. **CME Credit:** AMA Category 1. **Fee:** $100 (members), $150 (non-members).

Sponsor, contact: Amer. College of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014.

VASCULAR SURGERY FOR THE PRACTICING PHYSICIAN

2-day conference, March 23-24, 1974, Marc Plaza Hotel, Milwaukee, Wis.

Sponsor, contact: Medical College of Wis., 561 N. 15th St., Milwaukee, Wis. 53233.

CARDIOLOGY TODAY—RECENT ADVANCES IN CARDIOLOGIC TREATMENT & DIAGNOSIS

For: All physicians. 4-day course, March 25-28, 1974, Univ. of Iowa College of Med., Iowa City, Ia.

Hrs. of Instr.: 40. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 12.

Sponsor, contact: Univ. of Iowa Coll. of Med., Newton Rd., Iowa City, Ia. 52242.

Dermatology

ONE WEEK COURSE IN BASIC DERMATOLOGY

For: Family physicians. March 25-29, 1974, Chicago.

Hrs. of Instr.: 30. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 30.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Electrocardiography

BASIC ELECTROCARDIOGRAPHY

For: Family physicians. 5-day course, March 4-8, 1974, Chicago, Ill.

Hrs. of Instr.: 35. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 35.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

ELECTROCARDIOGRAPHIC INTERPRETATION OF ARRHYTHMIAS: A PHYSIOLOGICAL APPROACH

For: Cardiologists. March 25-27, 1974, Indiana Univ. Med. Center, Indianapolis, Ind.

Hrs. of Instr.: 24. **CME Credit:** AMA Category 1. **Fee:** $100 (members), $150 (non-members). **Reg. Limit:** 60.

Sponsor, contact: American Coll. of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014.

ELECTROCARDIOGRAPHIC DIAGNOSIS

For: All physicians. 3-day course, March 26-28, 1974, Towsley Center for CME, Ann Arbor, Mich.

Hrs. of Instr.: 21. **CME Credit:** AMA Category 1. **Fee:** $110.

Sponsor, contact: Univ. of Mich. Med. Cntr., Towsley Cntr. for CME, Ann Arbor, MI 48104.

Internal Medicine

IMMUNOLOGY OF INFECTIONS

For: Pediatricians, Internists, Family Physicians. Symposium, March 6, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

BASIC INTERNAL MEDICINE

For: Family physicians. 5-day course, March 18-22, 1974, Chicago, Ill.

Hrs. of Instr.: 40. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 50.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

INTERNAL MEDICINE REVIEW

For: Internists, Pediatricians, Family Physicians. Symposium, March 20-21, 1974, Atkinson Hotel, Indianapolis, Ind.

Hrs. of Instr.: 12. **CME Credit:** AAFP, AMA Category 1. **Fee:** $50.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

CHRONIC RESPIRATORY DISEASE PROGRAM

For: All physicians. 5-day conference, March 25-29, 1974, Indianapolis, Ind.

Hrs. of Instr.: 30. **CME Credit:** AMA Category 1.

Sponsor, contact: Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

Neurology

BASIC NEUROLOGY, PART I

For: All physicians. 5½-day course, March 25-30, 1974, Chicago, Ill.

Hrs. of Instr.: 44. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 80.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

CLINICAL NEURO-OPHTHALMOLOGY

For: Neurologists & Ophthalmologists. Symposium. March 27, 1974, Methodist Hospital, Indianapolis, Ind.

Hrs. of Instr.: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Obstetrics/Gynecology

ONE WEEK COURSE IN BASIC OBSTETRICS

For: Family physicians. March 25-29, 1974, Chicago.

Hrs. of Instr.: 35. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 20.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Otolaryngology

LARYNGOLOGY & BRONCHOESOPHAGOLOGY

For: Practicing otolaryngologists, thoracic surgeons. March 18-23, 1974, Univ. of Illinois Eye & Ear Infirmary, Chicago, Ill.

Hrs. of Instr.: 45. **Fee:** $300. **Reg. Limit:** 15.

Sponsor, contact: Dept. of Otolaryngology, Univ. of Ill. Coll. of Med., 1855 W. Taylor St., Chicago, IL 60612.

HEAD & NECK ANATOMY & CLINICAL OTOLARYNGOLOGY

For: Otolaryngologists. Symposium, March 18-29, 1974, Indianapolis, Ind.

Hrs. of Instr.: 112. **CME Credit:** AAFP, AMA Category 1. **Fee:** $650. **Regis. Limit:** 27.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Pediatrics

ADVANCES IN PEDIATRICS

For: Pediatricians. 2-day conference, March 7-8, 1974, Towsley Center for CME, Ann Arbor, Mich.

Hrs. of Instr.: 14. **CME Credit:** AMA Category 1. **Fee:** $75.

Sponsor, contact: Univ. of Mich. Med. Cntr., Towsley Cntr. for CME, Ann Arbor, MI 48104.

CHRONIC ILLNESS IN CHILDHOOD

For: Pediatricians. Half-day roundtable, March 20, 1974, Loyola University Medical Center, Maywood, Ill.

Hrs. of Instr.: 4. **Fee:** $10. **Regis. Deadline:** March 18, 1974.

Sponsor: Dept. of Pediatrics, Loyola Univ. Stritch Sch. of Med. **Contact:** Pediatrics Roundtables, c/o Eugene F. Diamond, M.D., 2160 S. 1st Ave., Maywood, IL 60153.

Radiology

LECTURE

For: Radiologists & Residents in Radiology. Lecture, March 21, 1974, Bismarck Hotel, Chicago, Ill.

Sponsor: Illinois Radiological Society. **Contact:** Raymond L. Del Fava, M.D., Secretary, Chicago Radiological Society, St. Francis Hospital, 3355 Ridge Ave., Evanston, IL 60202.

Surgery

MANAGEMENT OF COMPLICATIONS IN SURGERY

For: All physicians. March 11-14, 1974, Chicago, Ill.

Hrs. of Instr.: 28. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 55.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

PRF & POST OPERATIVE CARE OF PATIENTS FOR SURGEONS & SURGICAL SPECIALISTS

4-day course, March 12-15, 1974, Chicago, Ill.

Hrs. of Instr.: 31½. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 80.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

VASCULAR SURGERY

For: All physicians. 2-day conference, March 14-15, 1974. Towsley Center for CME, Ann Arbor, Mich.

Hrs. of Instr.: 14. **CME Credit:** AMA Category 1. **Fee:** $90.

Sponsor, contact: Univ. of Mich. Med. Cntr., Towsley Cntr. for CME, Ann Arbor, MI 48104.

SURGERY REVIEW

For: Surgeons. Symposium, March 14-15, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

BLOOD VESSEL SURGERY

For: Specialists. 5-day course, March 25-29, 1974.

Hrs. of Instr.: 40. **CME Credit:** AMA Category 1. **Fee:** $250. **Reg. Limit:** 40.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Trauma

HOSPITAL PROGRAM ON GENERAL SURGERY/TRAUMA

For: All physicians. Monthly clinical program, March 12, 1974, 8 p.m., Loyola Univ. Medical Center, Maywood, Ill.

Hrs. of Instr.: 2. **Fee:** none.

Sponsor: Chicago Committee on Trauma, American College of Surgeons. **Contact:** Arne E. Schairer, M.D., 30 N. Michigan Ave., Chicago, IL 60602.

HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA

For: All physicians. Monthly clinical program, March 19, 1974, 8 p.m., Illinois Masonic Hospital, Chicago,

Hrs. of Instr.: 2. **Fee:** none.

Sponsor: Chicago Committee on Trauma, American College of Surgeons. **Contact:** Howard W. Schneider, M.D., 238 W. 154th St., Harvey, IL 60426.

APRIL

MIDWEST CLINICAL CONFERENCE

For: All physicians. April 3-7, 1974, Conrad Hilton Hotel, Chicago, Ill.

CME Credit: AMA Category 1.

Sponsor, contact: Chicago Med. Soc., 310 S. Michigan Ave., Chicago, IL 60604.

"HOW TO IDENTIFY NEEDS IN CONTINUING MEDICAL EDUCATON"—2nd ANNUAL ILLINOIS CONGRESS ON CME

For: All interested in CME. Conference/workshop, April 18, 1974, Oak Brook Hyatt House, Oak Brook.

Hrs. of Instr.: 7. **CME Credit:** AMA Category 1. **Fee:** $25. **Reg. Limit:** 100.

Sponsor, contact: Ill. Council on CME, 360 N. Michigan Ave., Chicago, IL 60601.

Multi-Media Learning Materials—MEDCOM

One of the most complete collections of multi-media study materials for physicians, MEDCOM includes slides, video tapes, programmed instruction, illustrated study-guides, *etc.*, covering a wide variety of medical topics.

For full information, write to . . .
MEDCOM, Inc.
2 Hammarskjold Plaza
New York, N.Y. 10017

AMERICAN RHINOLOGIC SOCIETY
and
ILLINOIS MASONIC MEDICAL CENTER

present an INTRODUCTORY COURSE in

A. Functional Corrective Surgery Of The Nasal Septum And The External Nasal Pyramid

B. Rhinomanometry And Naso-Antral Manometry

C. Basic Principles Of Respiratory Physiology And Fundamental Diagnostic Tests—Pulmonary, Cardiac, Blood Gas Analysis, Nasal Function Tests, And Introducing Naso-pulmonary Function Tests

March 31 — April 6, 1974

at

Illinois Masonic Medical Center
836 Wellington Avenue, Chicago

PART C is planned and designed for all members of the medical profession and especially those in General Practice. It will be given in **four sessions from 5:30 P.M. to 9:30 P.M. on April 2-5, 1974,** in conjunction with The Annual Midwest Clinical Conference (Chicago Medical Society) and the Illinois State Medical Society 134th annual meeting.

Course Director—Maurice H. Cottle, M.D.

Part C Tentative Program will include:

"Basic Pulmonary and Cardiolgy Tests for Breathing and Anginal Difficulties"
"Highlights of Nasal Physiology. Cycles, Reflexes, Antrum Functions"
"Physics of Air Flow"
"Oxygen Diffusion and Transportation. Cellular Oxygen Metabolism"
"Rhinomanometry, An Important Aid in Diagnosis in General and Specialty Practice"
"Naso-Pharyngeal Obstruction and Pulmonary Hypertension, Cardiomegaly, and Cardiac Arrest (Especially in Children)"
"Arterial Gas Analysis. The Nose and Arterial Oxygen Tension"
"Laryngeal, Tracheal and Bronchial Obstructions and Heart and Lung Disease"
"Systemic Effects of Hypoxia—Acute and Chronic"
"Compliance Changes in the Lung due to Heart Disease"
"Disturbed Alveolar Ventilation and Effects on Lung, Heart, and Brain"
"Reflex Respiratory and Cardiovascular Effects of Stimulation of Receptors in the Nose and other Chemoreceptors"
"Breathlessness—Pain in Chest"
"Ways, Positions, and Patterns of Nasal and/or Oral Breathing. Relation to 'Difficulty of Breathing' and Heart Illness"
"Including the Nose in Pulmonary Function Tests: (A) Wedge Spirometer, (B) Computer"
"Work of Breathing Through the Nose and/or Mouth"
"Simple Apparatus for Some Minimal Functional Respiration Tests in Office Practice and at Bedside for the General Practioner"

Approved for credit by the
Council of Medical Education of the American Medical Association

For complete program and registration:

American Rhinologic Society
530 Hawthorne Place **Chicago, Illinois, 60657**

Tuition, Part C only: $50.00

Cardio Vascular Collapse During Gynecological Laparoscopy

(Continued from page 61)

References

1. Alexander G. G., Noe F. E., Brown E. L.: "Anesthesia for Pelvic Laparoscopy." *Anesth Analg* 48:14-18, 1969.
2. Seed R. F., Shakespeare T. F., Muldoon M. J.: "Carbon Dioxide Homeostasis During Anesthesia for Laparascopy." *Anesthesia* 25:223-231, 1970.
3. Smith, Benzie R. J., Gordon N. L. M., Kelman G. R., Swapp G. H.: "Cardiovascular Effects of Peritoneal Insufflation of Carbon Dioxide for Laparoscopy." *Brit Med J* 3:410-411, 1971.
4. Illinois Anesthesia Study Commission. Case No. 6914. *Bulletin Illinois Society Anesthest.* 3:24-27, 1971.
5. Arthure H.: "Laparoscopy Hazard." *Brit Med J* 4:492, (Nov.) 1970.
6. Desmond J., Gordon R. A.: "Ventilation in Patients Anesthetized for Laparoscopy." *Canad Anaesth Soc J* 17:378-387, 1970.
7. Muldoon M. J.: "Laparoscopy Hazard." *Brit Med J* 1:51, 1971.
8. Horwitz S. T.: "Laparoscopy in Gynecology." *Obst & Gynec Survey* 27:1-13, 1972.
9. Alexander G. D., Brown E. M.: "Physiologic Alterations During Pelvic Laparoscopy." *Amer J Obst Gynec* 105:1078-1081, 1969.
10. Black G. W., Linde H. W., Dripps R. D., Price H. L.: "Circulatory Changes Accompanying Respiratory Acidosis During Halothane Anesthesia in Man." *Brit J Anaesth* 31:238-246, 1959.
11. Motew M., Ivankovich, A. D., Bienarz J., et al: "Cardiovascular Effects, Acid Base and Blood gas Changes during Laparoscopy." *Am J Obst Gynec* 115:1002-10012, 1973.
12. Hodgson C., McClelland R. M. A., Newton J. R.: "Some Effects of the Peritoneal Insufflation of Carbon Dioxide at Laparoscopy." *Anaesth* 25:382-389, 1970.
13. El-Etr, A. A.: Personal communications.
14. Oppenheimer M. J., Durant T. M., Stauffer H. M., et al: "In Vivo Visualization of Intracardiac Structures with Gaseous Carbon Dioxide; Cardiovascular-respiratory Effects and Associated Changes in Blood Chemistry." *Am J Physiol* 186:325-334, 1956.
15. Kunkler A., King H.: "Comparison of Air, Oxygen and Carbon Dioxide Embolization." *Ann of Surg* 149:95-99, 1959.
16. Freidberg, C. K.: DISEASES OF THE HEART. W. B. Saunders, co. 1966.
17. Riegel A. R.: "Pneumothorax Nach Diagnostieschem Pneumoperitoneum Bei Laparoscopie." *Beitr Klin Tuberk* 107:467-473, 1952.

View Box

(Continued from page 56)

DIAGNOSIS: *Dermatomyositis*—Note the streaky calcifications which are seen in the thighs and the amorphous calcification seen in the region of the pelvis. The diffuse soft tissue calcification is attributed to degeneration of collagen tissue. It is a disease which occurs primarly in young females. The association of a diffuse rash followed by muscle and soft tissue calcification is characteristic of the disease. Radiologically changes have been described in the swallowing mechanism due to involvement of the striated muscle. Changes in the lungs have been described. There is an association of malignant tumors in about 10% of the patients with myopathy. ◄

Gonorrhea in Women

A total of 250 women, 100 of them named contacts of men with gonorrhea, were tested for infection. Each had prepared smear and culture specimens from urethra, endocervix, and vagina. The smears were Gram-stained and examined immediately. Cultures were taken using Stuart's transport medium with later inoculation of both selective and non-selective media for each specimen.

It was shown that examination of specimens from urethra and endocervix gave results superior to those found on examination of vaginal material alone. The study revealed that nearly one infected woman in three would have been missed if vaginal material only had been examined. Failure to secure a prompt scientific diagnosis has serious epidemiological implications.

Our results find support in the work of others. We conclude that the suggestion in some quarters that examination of vaginal material for the detection of gonococci is adequate, should be abandoned. Any who feel unwilling to accept this view should at least supplement their testing with examination of urethral and endocervical specimens. (M. N. Bhattacharyya, et al.: "Diagnosis of Gonorrhea in Women: Comparison of Sampling Sites." *Brit. Med. Journal* (June 30) 1973, pgs. 748-750.)

FOR YOUR EYES ONLY!

A CONFIDENTIAL SOURCE OF UNSECURED CREDIT—UP TO $7,500

Larger amounts considered upon request

Here are the only qualifications: $20,000 annual income; between 30 and 65 years of age; and the desire to borrow at least $2,000 for 12 to 36 months in complete confidence.

Fill out and return our brief loan application. No references are contacted. No endorsers are needed. No additional information is ever required. Everything is handled in total privacy by unmarked mail. Your application will be processed and a check mailed in approximately 2 weeks.

Call Collect Or Write C. W. Conner For Your Confidential Loan Application.

Murdock
Acceptance Corporation
P. O. Box 158 / Memphis, Tenn. 38101
901/523-1461

Integument!

Our skin—the human integument—covers us, defines us, protects us. But skin is subject to cuts, burns, abrasions. And infections. Neosporin Ointment fights infection by providing broad antibacterial action against susceptible skin invaders. It contains antibiotics that are rarely used systemically, reducing the risk of sensitization.



INDICATIONS: *Therapeutically*, used as an adjunct to appropriate systemic therapy for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

PRECAUTION: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Complete literature available on request from Professional Services Dept. PML.

NEOSPORIN® Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

Each gram contains: Aerosporin® brand Polymyxin B Sulfa 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 m (equivalent to 3.5 mg neomycin base); special white petrolatu q.s. In tubes of 1 oz. and ½ oz. and 1/32 oz. (approx.) foil packet

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Marcus P. Hatfield – The First Pediatrician at Northwestern

(Continued from page 63)

men. Abt resigned and was appointed extramural professor of pediatrics at Rush Medical College. Abt returned to Northwestern as chairman in 1909.

Acknowledgements

I am indebted to Mr. William Beatty and to Miss Georgia Price for the use of the excellent facilities at Northwestern University Medical School Library and Dr. L. B. Arey, Dr. R. B. Lawson, Dr. J. J. Boehm, Mr. W. Beatty, Dr. H. L. Moffet, and Dr. H. S. Traisman for reviewing and commenting upon the manuscript. ◄

References

1. Abt, I. A. Baby Doctor, New York, McGraw Hill Book Co., 1944.
2. Arey, Leslie B., Northwestern University Medical School, 1859-1959, Evanston, Ill., Northwestern University, 1959.
3. Danforth, Isaac N., The Origin and Early Years of Wesley Memorial Hospital, Typed Manuscript, 1909-10, N.U.M.S. Library.
4. Davis, N. S., Notes from Lectures, 1881, N.U.M.S. Library.
5. Hatfield, M. P., The Acute Contagious Diseases of Childhood. Chicago, G. P. Engelhard and Co., 1901.
6. Hatfield, M. P., A Compend of Diseases of Children, Philadelphia, P. Blakiston's Sons and Co., 1890, 1896, 1903.
7. Hatfield, M. P., The Physiology and Hygiene of the House in Which We Live, New York, Chautaugua Press, 1887.
8. History of Medicine and Surgery and Physicians and Surgeons of Chicago, Chicago, The Biographical Publishing Corp., 1922, pp. 144, 146, 363.
9. List of the Faculty, 1905, Typed Manuscript, N.U.M.S. Library. Northwestern University Medical School Catalog, 1879-1968.
10. Report of the School's Activities, 1923, Typed Manuscript, N.U.M.S. Library.
11. Scrapbook of M. P. Hatfield, N.U.M.S. Library.
12. Wire, G. E., Lecture Notes on Quine, Hollister, Jewell and Hatfield at Chicago Medical College, 1881-82, Vol. 2, 1881-82, N.U.M.S. Library.

COOK COUNTY
Graduate School of Medicine

CONTINUING EDUCATION COURSES
STARTING DATES, 1974

SPECIALTY REVIEW IN SURGERY, Part II, February 18
SPECIALTY REVIEW IN PEDIATRICS, March 25
NEUROLOGY, Part I, Basic, One Week, March 25
NEUROPATHOLOGY REVIEW, One Week, April 1
MANAGEMENT OF SPECIAL SURGICAL PROBLEMS, Feb. 4
PRE & POSTOPERATIVE CARE OF PATIENTS, 4 Days, Mar. 12
MANAGEMENT OF COMPLICATIONS IN SURGERY, March 11
BLOOD VESSEL SURGERY, One Week, March 25
SURGERY OF GASTROINTESTINAL TRACT, One Week, April 8
BASIC OBSTETRICS, One Week, March 25
BASIC GYNECOLOGY, One Week, April 1
ADVANCES IN INTERNAL MEDICINE, One Week, April 8
BASIC ELECTROCARDIOGRAPHY, One Week, March 4
BASIC INTERNAL MEDICINE, One Week, March 18
FAMILY PRACTICE REVIEW, One Week, April 8
DIAGNOSTIC RADIOLOGY, One Week, April 15
BASIC DERMATOLOGY, One Week, March 25
ADVANCED CARDIOLOGY, One Week, April 15
STATE & NATIONAL BOARD REVIEW, Basic & Clinical, April 29 & May 5

Information concerning numerous other continuation courses available upon request.

Address:
REGISTRAR, 707 South Wood Street,
Chicago, Illinois 60612

TAX-FREE MUNICIPAL BONDS

Safety Marketability

M. B. VICK & COMPANY
Established 1933
120 South La Salle Street
Chicago, Ill. 60603
312-346-3344

Satisfying the needs of individual investors for over 40 years.

Call or write one of our Municipal Bond specialists

Name.....
Address.....
City.....
Zip..... State.....

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

ALBION: Population 2,000. Family Physician for community located in Southern Illinois in Edwards County with doctor-patient ratio of 1:3500. Located one hour from metropolitan area. Office space available. Financial assistance available. Contact: Don Broster or Jerry Wiseman, Citizens National Bank of Albion, 618-445-2344. (4)

AMBOY: Population 2,200. Shopping area—approximately 6000. Located 100 miles west of Chicago; just south of the East-West Tollway. Office space available. Year 'round recreation. Complete downtown shopping areas. Contact: Larry G. Hawes, 220 East Main St., Amboy, 61310, 815-857-3625. (4)

BERWYN: 5 Emergency Room Physicians needed. 442-bed hospital; suburban Chicago. Patient diagnosis, management and disposition. University of Illinois Abraham Lincoln School of Medicine appointment available. 3 years emergency experience or emergency medicine residency (other residencies considered). Contact: Kenneth Kessel, M.D., E.R. Director, MacNeal Memorial Hospital, Berwyn, 60402, 312-787-300. (4)

BLOOMINGTON: General Practitioners, Internists, Pediatricians and a Surgeon needed to help establish a multi-specialty clinic in a new Erdman Building. Corporate practice with all the usual benefits. Contact: Paul G. Theobald, M.D., 1210 Towanda Plaza, Bloomington, 61701, 309-828-6051. (1)

BLUE ISLAND: Gastroenterologist, Opthalmologists and Otolaryngologist urgently needed in this south suburban community. City of approx. 20,000, but hospital and clinic serving approx. 250,000. Pronger-Smith Clinic, old, well-established clinic in beautiful new building. Generous starting salary. Contact: Gerald A. Caress, 2320 W. High St., Blue Island, 60406, 312-388-5500. (2)

CARBONDALE: 30 man multispecialty group. University community with medical school. Mild climate with recreational facilities. Drawing area of 500,000. Contact: Dr. Donald Darling, Carbondale Clinic, Carbondale, 62901, 618-549-5311. (4)

CARLINVILLE: City population 6000. County seat serving 25,000. Six physicians in city. 68-bed general hospital. Midway between Springfield, Ill. and St. Louis—one hour drive. Financial assistance available. Contact: Jim Rives, P.O. Box 35, Carlinville, 62626, 217-854-3141. (4)

CARROLLTON: Ample excellent opportunities in Greene County for Family Physician. Group practice being set up in new office accommodating 4-5 M.D.s next to hospital. For further information, contact: Dr. Caselton or Dr. Chung or Roy Shoemaker in Carrollton, 62016, 217-942-6946. (4)

CARTHAGE: County seat of Hancock County; population 24,000. Need Family Practitioners, Radiologist, Pathologist, Internist. Opportunity for solo or group practice. Minimum guaranty offered by 130-bed hospital and nursing home. State University nearby. Contact: Harold A. Dietz, Administrator, Memorial Hospital, Carthage, 62321, 217-357-3131. (4)

CHENOA: Rural area, 100 miles south of Chicago on I-55. Looking for one or two physicians to do family practice. Hospital facilities nearby. Financial assistance and office space can be arranged. Contact: R. J. Walker, National Bank of Chenoa, Chenoa, 61726, 815-945-2311. (4)

CHICAGO: Young multispecialty group with 4 locations. 24 physicians at present. Need Family Physicians or General Internists. Hospital appointments assured. Financial reward comensurate with effort. Opportunity to grow with group. Contact: Dr. Arthur Kunis, 3157 W. Lawrence Ave., Chicago, 60625, 312-478-1939. (6)

CHICAGO: Openings for Medical Specialists and General Practitioners. We are seeking clinicians and supervisors to provide comprehensive health care to City residents through network of Neighborhood Health Centers. Competitive salaries, complete fringe benefits. Contact Mr. Gerald O'Sullivan, Personnel Office, Board of Health, Civic Center, Chicago, 60602, 312-744-3805. (3)

CHICAGO: Privately owned clinic, south side. 44-hour week. No night work. Contact: Robert C. Parro, Professional Medical Center, Inc., 104 E. 51st St., Chicago, 60615, 312-268-3400. (4)

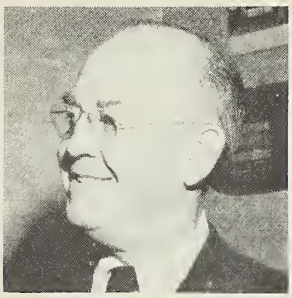
CHRISTOPHER: Area population 20,000. Office facilities for two family physicians. New hospital and nursing home being built in Christopher. Financial assistance available. New subdivisions, excellent schools, churches. Heart of five new lakes and recreation areas. Near Southern Illinois University. Contact: Jeff Troutt, Box 5, Christopher 62822, 618-724-2928. (4)

EFFINGHAM: Service area 60,000—Central Illinois at intersection of I-57 and I-70. Family Physician, Pediatrician, Internist, Cardiologist, Urologist, Orthopedic Surgeon. Clinic or solo practice. Progressive community. Contact: Don Kabbes, 503 North Maple Street, Effingham, 62401, 217-342-2121. (4)

FAIRBURY: Service population 15,000. Young medical community; three clinics; excellent hospital. Housing, office, financial assistance available. Enjoy small community living, be near metropolitan areas, and enjoy all the services necessary for family practice. Contact: Donald Patterson, Administrator, Fairbury Hospital, 519 S. Fifth Street, Fairbury, 61739, 815-692-2346. (4)

FAIRFIELD: Family Practitioners, Internists, and Pediatricians wanted. Town of 6,000 population, trad-

Obituaries



***William E. Adams,** 71, died November 25, 1973, in Iowa. Dr. Adams was active in organized medicine; he was Chairman of the Board and Vice President of the Illinois State Medical Society; Past President of Chicago Medical Society; Past President of the American Association for Thoracic Surgery; Past President of the American College of Chest Physicians and a founder of the American Board of Thoracic Surgery.

Dr. Adams, a graduate of the University of Iowa College of Medicine, served at the University of Chicago School of Medicine for over 40 years; during those years he served as Chairman of the Department of Surgery. Before his retirement this past fall, Dr. Adams had served the last six years as Assistant Director of the American College of Surgeons.

A noted general and thoracic surgeon, Dr. Adams assisted in performing the first successful operation for the removal of an entire lung for cancer in 1933 and in 1938 he developed the technique for, and with the assistance of the late Dr. Dallas B. Phemister, performed the first successful one-stage removal of cancer of the esophagus.

***Barnes, James H.,** Chicago, died November 15, at the age of 69.

***Brown, Charles Edward,** Penfield, died May 27, at the age of 63. He graduated from the University of Illinois in 1935.

***Burhans, Donad Lucas,** Peoria, died June 27, at the age of 54. He was a 1944 graduate of the University of Cincinnati.

***Cahan, Meyer,** Chicago, died October 11, at the age of 70. He was active in medical research and teaching and was a member of the Weiss Hospital staff.

***De Vries, Jerry,** Ottawa, died November 4, at the age of 74. He graduated in 1928 from the Rush Medical School, and was an active staff member at the Ottawa Community Hospital.

***Feinberg, Louis,** Chicago, died November 16, at the age of 64. He graduated in 1934 from Rush Medical School.

Fox, Donald Richard, Barrington, died July 24, at the age of 46. He graduated from the Loyola University Stritch School of Medicine.

***Hermetet, James Henry,** Macomb, died October 10, at the age of 71. He graduated from Johns Hopkins Medical School in 1928. Dr. Hermetet began his practice in 1930, in Macomb, and was head of Marietta Phelps Hospital. He also was a member of the surgical staff at McDonough District Hospital and past president at the McDonough County Medical Society.

***Hletko, Peter P.,** Hinsdale, died on October 17, at the age of 71. He graduated from Loyola Stritch School of Medicine in 1929.

****Jones, Alden B.,** Wheaton, died October 26, at the age of 82. He was a former president of the DuPage County Medical Society. Dr. Jones graduated in 1919 from the U. of Pennsylvania and was a physician for more than 50 years.

***Moran, Alfred E.,** Evergreen Park, died October 19, at the age of 44. He was a graduate of Loyola University Stritch Medical School and was affiliated with the Little Co. of Mary Hospital in Evergreen Park.

Murray, Joel Elizabeth, Chicago, died May 24, at the age of 32. He was a 1966 graduate of the University of Chicago.

***Nielson, Paul E.,** Chicago, died October 15, at the age of 58. He graduated in 1944 from Washington University, St. Louis, Missouri.

***Nowak, John M.,** Skokie, died November 4, at the age of 72. He graduated in 1930, from the University of Illinois.

***Simkin, William,** Chicago, died November 13, at the age of 79. He was a 1925 graduate of Rush Medical School. Dr. Simkin was on the staff of Bethany Methodist and Lutheran General Hospitals.

***Torricelli, William V.,** Kincaid, died October 3, at the age of 49. He graduated in 1953 from the University of Illinois.

***Trizna, Joseph L.,** Joliet, died November 6, at the age of 66.

Vardaman, Howard Francis, Chicago, died June 1, at the age of 61. He was a 1952 graduate of Northwestern University School of Medicine.

****Wilburn, Homer V.,** Chicago died October 23, at the age of 85. He was a physician for more than 50 years.

**Denotes member of ISMS*
***Denotes member of 50-year Club and ISMS*

CLASSIFIED ADVERTISING

Positions & Practice Opportunities

WANTED: OB-GYN, SURGEON and INTERNIST for nine man group. Thirty miles southwest of Chicago, excellent hospital, housing and schools. $30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

GASTROENTEROLOGIST WANTED for beautiful multi-specialty clinic in south suburbs of Chicago. Must be licensed in Illinois. Write: Mr. G. A. Caress, 2320 W. High St., Blue Island, Ill. 60406 or Call: (312) 388-5500.

FAMILY PRACTICE OPENING—January, 1974 in two man office. Cashmere, Washington, outstanding orchard community. Scenic area with unlimited recreation opportunities. Partner retiring. Initial salary and early partnership. Edgar A. Meyer, M.D. (Iowa '50) ABFP, 303 Cottage Ave., Cashmere, Washington 98815.

ATTENTION PHYSICIANS! CHICAGO MEDICAL CENTERS—Welfare area in need of physicians. Please contact: Mr. Robert Fields (312) 236-2555.

GENERAL INTERNISTS and **GENERALISTS:** For growing sub-sections of 45 man medical department, including allergists, psychiatrists, neurologists, all sub-specialties and expanding primary care section. Multispecialty group of 120. Large patient population and area referral. Functioning HMO. Generous salary and fringe benefits. Peaceful setting near Wisconsin vacationland and cities. Good schools, cultural advantages, Junior College. Educational and research programs. Liberal schedules, little practice pressure. New Clinic and hospital developing. Write or call J. L. Struthers, M.D., Marshfield Clinic, Marshfield, Wisconsin 54449.

INTERNIST or **GENERAL PRACTITIONER:** An insurance company has an opening for the position of Staff Physician in its Medical Department in Chicago. Full time. Fringe benefits. Salary negotiable. Office population. Send curriculum vitae to Box 823, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

WANTED: FAMILY PRACTITIONERS, PEDIATRICIANS, INTERNISTS, and **OBSTETRICIANS** for dynamic municipal Midwest Health Department providing innovative primary care. Faculty appointment available. Salary $27,500-$30,000 negotiable. Must be eligible for Ohio license. Reply P.O. Box 238, Cincinnati, Ohio 45202.

Two Board certified or eligible **OB-GYNES** are wanted to take over the practice of two retiring members of a busy OB-Gyne practice. Remaining OB-Gyne man needs help in a rapidly growing community of 80,000, 40 miles west of Chicago. Contact George J. Shimkus, M.D., Aurora Women's Clinic, S.C., 143 So. Lincoln Avenue, Aurora, Illinois 60505.

INTERNIST WANTED, Occupational Medicine Department, Chicago. Office employee population. Regular hours. No work nights or weekends. Excellent fringe benefits. Salary negotiable to mid-thirties. Send curriculum vitae to Box 824, c/o Illinois Medical Journal, 360 North Michigan Avenue, Chicago, Illinois 60601.

FOR SALE, LEASE OR RENT

PROFESSIONAL OFFICE FOR SUBLEASE, part-time or full-time, in brand new professional building, Downers Grove. Waiting room, consulting room, wash room. Contact: A. Guschwan, M.D., 2112 West Jefferson, Joliet, Illinois 60435. Phone (815) 725-1188.

FOR RENT: NORTH SIDE CHICAGO 3 ROOM OFFICE SUITE with reception room. Air conditioned. Janitor service, 1046 Wilson Avenue, Chicago, Illinois. Telephone: Agent, David C. Goldfine (312) 321-9380.

FOR RENT: Suites available in a recentiy completed Medical Center just ½ Mile from the new proposed Hospital in Barrington, Illinois. Each suite, 800 sq. ft., is elegantly finished and absolutely indedendent, incl. W/R, A/C, AM-FM, etc. Ample parking. Reply Box Number 815, c/o Illinois Medical Journal, 360 North Michigan Ave., Chicago, Illinois 60601.

FURNISHED OFFICE SPACE FOR RENT—reasonable, available in the South Shore area of Chicago. Immediate possession and patient load for Medical Doctor. No need to buy practice. Contact Mr. Feffer: (312) 493-7733.

OUR NEWEST OFFICE COMPLEX is now leasing its medical building. Custom built suites overlook a beautiful golf course. In this above average income area; our rents are reasonable, including a generous decorating allowance. Two minutes from a major Joliet hospital Brochure available. Venterra Inc., 3033 West Jefferson, Joliet, Ill. 60435.

MEDICAL ARTICLES FOR SALE

NEED EQUIPMENT or **SUPPLIES? ?** Your new examining rooms are in stock: Otoscopes, ophthalmoscopes, blood pressure equipment, stethoscopes, electrocardiographs, ultra sound, examining tables, surgical instruments, lamps, microscopes, hyfrecators, diatherms, paper gowns, drape sheets, paper towels, dressings, centrifuges, autoclaves, hemoglobinometers, syringes & needles, table paper, sutures, plastic gloves, oxygen, leather goods, scales, fracture appliances, pregnancy tests, laboratory supplies, audiometers. For Free **DISPOSABLES CATALOG** write or call: **THE PHYSICIANS MART,** 5637 West North Avenue, Chicago, Illinois 60639, Telephone: (312) 237-5343.

X-RAY AND MEDICAL EQUIPMENT FOR SALE: Two complete Profex X-ray units, 100 MA and 300 MA with spot film fluoroscopy, tilt table. Excellent condition. Other equipment also. Call: (312) 627-3404.

Practices & Positions Wanted—Paramedical*

CAREER MINDED, experienced **MEDICAL SECRETARY** with Bookkeeping and Payroll knowledge. Call Evenings (312) 627-3132.

NOTE:

*Professional qualifications of Paramedical Personnel are subject to review by prospective physician employers.

BLUE SHIELD REPORT FOR *Illinois Physicians*

Causes of Most Delays In Payment

With the continuing increase in the number of Blue Shield subscribers enrolled in our programs and the higher volume of Physician's Service Reports being processed by Blue Shield, our Claims Department has asked us to emphasize the items in Service Reports where errors or omissions cause most delays.

Those recurring with the highest frequency are: (1) Incorrect spelling of subscriber or patient's name (2) improper entry of group and subscriber or certificate number (3) omission of age (4) where service was rendered (5) incomplete descriptions of services and (6) services and fees of other physicians included on one Service Report.

Delays can be reduced or eliminated entirely by following a checklist when completing the Physicians' Service Report forms. The one that follows has been helpful to many physicians and their medical assistants when completing and submitting Service Reports for payment.

(1) To eliminate spelling errors of subscriber or patient's name, use the patient's Blue Shield Identification Card if available, and print or type on the Physician's Service Report after double-checking spelling. Copy group and subscriber number exactly as it is shown on the Identification Card. *Do not include codes shown on the card.*

(2) Age of the patient must be stated (date of birth indicated if possible).

(3) Designate place of service (hospital inpatient, hospital outpatient, office, home). Often this is omitted.

(4) Include dates of service, date of admission and discharge if hospital patient, date of surgery, if any; and number of daily hospital visits if for medical (non-surgical care).

(5) Indicate if an injury occurred at patient's place of employment. (Give nature of injury and how it occurred).

(6) Provide diagnosis; use standard name of operation if any, and give sufficient descriptions. For example:

Vein ligations—stripping, multiple resections, both greater and lesser saphenous, unilateral or bilateral;

Lacerations—Location, length and depth of wound; identification of vessels, muscles and tendons repaired, if any.

A copy of the operative report attached to the Physician's Service Report may be used but is not necessary. When reporting surgical procedures, please use standard medical nomenclature.

(7) Describe unusual circumstances.

(8) Check only the type of service personally rendered indicating date(s) and description of service(s). If other physicians have also rendered services each must submit his own Physician's Service Report.

(9) Indicate fee for each service reported and whether fee has been paid by patient. This is particularly important so that payment can be made to physicians on the basis of their Usual charges for those Blue Shield members who are protected by our Usual and Customary program.

(10) Claims for anesthesia service should include the following information on the Blue Shield Service Report: (a) Date of anesthesia service (b) anesthesia time (c) name of surgical procedure (d) fee for anesthesia service.

Particular attention should be given to claims submitted for anesthesia administered during a dilation and curretage. Please indicate whether the procedure was performed for obstetrical or non-obstetrical purposes.

(11) Claims for radiation therapy are often delayed because the diagnosis (or reason for treatment) is not included on the radiologist's service report.

(12) Signature of the physician rendering the service must be on the Physician's Service Report.

Brief Summary of Limitation on Liability for Non-Covered Part B Services

Interim instructions that apply to the determination of limitation on liability of beneficiary, physician or supplier for non-covered services furnished after October 30, 1972 have been issued to Medicare carriers by the Department of Health, Education and Welfare.

Section 1879 of the Medicare Act, as described by HEW, explains the criteria for determining which party is responsible for payment of charges in assigned claims denied by the carrier, and the mechanism of procedure for each party for a determination of liability or exemption of payment by the carrier.

Review and Hearing Determinations

The determination of liability for payment of non-covered services or supplies—those not considered by Medicare as "reasonable and necessary for the diagnosis or treatment of an illness or injury, to improve the functioning of a malformed body, or constituting custodial care" will not be made during the initial processing stage of the claim by the carrier (Blue Shield for Cook County).

Beneficiary, physician or supplier may request a review of a denied claim when charges are disallowed by the carrier as "not reasonable and necessary" or custodial. The Part B Medicare carrier will first determine whether the services or supplies in controversy meet the criteria of "reasonable and necessary," then proceed to determine in the hearing and review process whether or not liability exists with beneficiary, physician or supplier for the payment of charges.

In every review and hearing case, there is a two-stage determination made by the carrier:

(1) Determination is made whether and when the beneficiary knew or could have been expected to know that the services were not "reasonable and necessary." If the beneficiary had, or could be expected to have knowledge of the non-coverage, the physician or supplier can seek payment from the beneficiary.

(2) If a determination is made that the physician or supplier (but not the beneficiary) knew or could be expected to know that the services or supplies were not "reasonable and necessary," he may not pursue payment of those services or supplies from the beneficiary.

Only when it is determined that neither beneficiary, physician or supplier did not know or could be expected to know that services furnished were not "reasonable and necessary" will Medicare accept responsibility for payment of the charges.

Reviews in assignment cases are conducted at the request of either beneficiary, physician or supplier when assignment is accepted. Frequently, the review request is received from only one of the parties. However, notification will go to both parties.

If the determination exempts the beneficiary from the payment, the physician or supplier may have reason to show that the beneficiary's liability should not have been waived. He then has recourse to request that a hearing and review process be allowed by the carrier. The rights of all parties are thus protected under the new regulations.

(Note: Additional details on the regulations will be published in subsequent issues of "Ask Blue Shield About Medicare").

Concurrent Medical Care

Part B Medicare regulations state that no payment can be made for medical or surgical services or for supplies which are not considered "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."

Medicare benefits *are* provided for concurrent care when the medical necessity exists. This could occur when the patient is seriously ill and the special skills of two or more physicians are required on a continuing basis. Examples would be for a patient with a serious heart disease who undergoes major surgery, a patient who develops a pulmonary embolism or pneumonia during a postoperative period, or the cancer patient undergoing radiotherapy who develops cardiac or other medical or surgical problems.

Concurrent care should not be confused with continuing care by a consultant. When a consultant physician assumes the continuing care of a patient he becomes the attending physician, at least for that illness or portion of the illness that is mutually agreed upon by the original attending physician and the consulting physician. In this situation, Medicare benefits are available only for one physician at a time.

Benefits are available for concurrent care only when the medical need is clearly stated either in the diagnoses or by separate statement from the attending physician.

SSA Certifies New Laboratories

The following laboratories have been certified for Medicare participation by the Social Security Administration:

Azteca Laboratories
3166 N. Lincoln Ave.
Chicago, Illinois 60657
Provider Number 14-8265
Effective Date: July 20, 1973

Health Maintenance Systems Labs
27 South Wabash Avenue
Chicago, Illinois 60603
Provider Number 14-8267
Effective Date: November 14, 1973

IMJ

Illinois Medical Journal

FEBRUARY, 1974 Vol. 145, No. 2 CONTENTS

Clinical Articles

115 Adult Endocardial Fibroelastosis Following Electric Shock
Efren C. Naguit, M.D. and Herbert Dexheimer, M.D.

118 Repeat Cesarean Section in a Low Socio-Economic Population
Joseph S. Dickstein, M.D., Murray Brown, M.D., Jack Zackler, M.D., and Stuart Abel, M.D.

121 Thymoma, Erythroid Hypoplasia and Myasthenia Gravis
Report of a Case with Ultrastructural Study
Balbino B. Fernandez, M.D. and Charles Hartman, M.D.

125 Meckel's Diverticulum
Kelly M. Berkley, M.D., F.A.C.S.

128 Pediatric Perplexities: Acute Yellow Phosphorus Rat Poisoning
Sudha Rao, M.D. and Rowine Hayes Brown, M.D., J.D.

Medical Legal Review

132 The New Supplemental Security Income Program
A Prospectus for the Medical Community
Harry F. Grant, M.D.

(Contents continued overleaf)

Features

95 President's Page
108 Clinics for Crippled Children
133 Editorial
134 EKG of the Month
135 Membership Forum
136 View Box
139 Doctor's News
144 New Pharmaceutical Specialties
148 ISMS Guide to Continuing Medical Education
150 Pulse of the Doctor's Wife
152 Physician Recruitment
155 Obituaries

(Cover by Alicia Kolton)

Staff

Editor . . . **Theodore R. Van Dellen, M.D.**

Managing editor . . . **Richard A. Ott**

Assistant editor . . . **Joyce Gallagher**

Executive administrator . . . **Roger N. White**

PUBLICATIONS COMMITTEE

Jacob E. Reisch, M.D., Springfield, *Chairman*
Eugene T. Hoban, M.D., Oak Park
Frederick E. Weiss, M.D., Harvey
James A. McDonald, M.D., Geneva
Warren W. Young, M.D., Crete

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Medical Progress: Harvey Kravitz, M.D., Skokie
Contributor in Maternal Death Studies: Robert Hartman, M.D.
Contributor in Pediatric Perplexities: Ruth A. Seeler, M.D., Chicago
Contributor in Trauma Medicine: David Boyd, M.D.C.M., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood

ILLINOIS STATE MEDICAL SOCIETY

360 N. Michigan Ave., Chicago, 60601

OFFICERS

Willard C. Scrivner, M.D., President
6600 West Main, Belleville 62223

Fredric D. Lake, M.D., President-Elect
1041 Michigan Avenue, Evanston 60202

Paul W. Sunderland, M.D., 1st Vice-President
214 N. Sangamon St., Gibson City 60936

Charles J. Weigel, M.D., 2nd Vice-President
7579 Lake Street, River Forest 60305

Jacob E. Reisch, M.D., Secretary-Treasurer
1129 S. 2nd Street, Springfield 62704

HOUSE OF DELEGATES

Andrew J. Brislen, M.D., Speaker of the House
6060 S. Drexel Blvd., Chicago 60637

James A. McDonald, M.D., Vice-Speaker
13 South Second Street, Geneva 60134

TRUSTEES

Chairman of the Board: William M. Lees, M.D.
6518 North Nokomis, Lincolnwood 60646

1st District: 1974, Joseph L. Bordenave, M.D.
1665 South Street, Geneva 60134

2nd District: 1974, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364

3rd District: 1976, David S. Fox, M.D.
20829 Greenwood Center Court, Olympia Fields 60461

3rd District: 1976, Robert T. Fox, M.D.
2136 Robin Crest, Glenview 60025

3rd District: 1975, Eugene T. Hoban, M.D.
6429 North Avenue, Oak Park 60302

3rd District: 1975, Joseph H. Skom, M.D.
707 Fairbanks Ct., Chicago 60611

3rd District: 1974, William M. Lees, M.D.
6518 North Nokomis, Lincolnwood 60646

3rd District: 1974, George Shropshear, M.D.
1525 East 53rd Street, Chicago 60615

3rd District: 1974, Philip G. Thomsen, M.D.
13826 Lincoln Avenue, Dolton 60419

3rd District: 1976, Frederick E. Weiss, M.D.
15643 Lincoln, Harvey 60426

3rd District: 1975, Warren Young, M.D.
3450 Haweswood Drive, Crete 60417

4th District: 1976, Fred Z. White, M.D.
723 North 2nd Street, Chillicothe 61523

5th District: 1976, A. Edward Livingston, M.D.
326 Fairway Drive, Bloomington 61701

6th District: 1975, Mather Pfeiffenberger, M.D.
State and Wall Streets, Alton 62002

7th District: 1976, Arthur F. Goodyear, M.D.
142 East Prairie, Decatur 62523

8th District: 1976, Eugene P. Johnson, M.D.
P.O. Box 68, Casey 62420

9th District: 1975, Warren D. Tuttle, M.D.
203 North Vine Street, Harrisburg 62946

10th District: 1975, Herbert Dexheimer, M.D.
301 S. Illinois, Belleville 62220

11th District: 1974, Joseph R. O'Donnell, M.D.
444 Park, Glen Ellyn 60137

Trustee-At-Large: Frank J. Jirka, Jr., M.D.
1507 Keystone, River Forest 60305

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/ Clinical Practice.*

Published by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601 (312-782-1654)

Copyright, 1974. The Illinois State Medical Society.

Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail).

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.



It's Up To You

As the new year began, the Illinois State Medical Society proved that sometimes, something can be accomplished by saying *NO*!

For the time being, we have gotten our message to HEW bureaucrats.

The message? ISMS will not comply with their plan for PSRO.

"Non-compliance" will be the ISMS position pending a special session of the House of Delegates within the next few weeks to reassess our position. HEW forced this posture when it announced PSRO area designations in December and completely ignored ISMS recommendations for a state-level unified PSRO in Illinois. However, the fragmentation of Illinois into seven PSRO areas hardly came as a surprise to medicine's seasoned observers of the Washington bureaucracy.

Likewise, the ISMS position was predictable and, in fact, mandatory. Last year, the House directed ISMS "to create a unified PSRO plan for Illinois under conditions favorable to physicians." The resulting plan was to be implemented through the Illinois Professional Standards Review Organization (IPSRO) and Local Medical Review Organizations (LMRO) composed of and directed by area MDs and osteopaths who would perform the review functions.

This plan received strong support from hospital and nursing home associations, insurance carriers, the Illinois Foundation for Medical Care, regional foundations and others at an HEW hearing last August. We carried our fight for statewide designation to Washington, realizing that attempts by the federal government to deal with physicians in small groups possibly signaled a "divide and conquer" tactic.

Yes! We suffered a setback when the area designations were announced.

ISMS now is proceeding with a coordinated statewide plan for further development and improvement of existing utilization review programs without federal funding. We are determined to fulfill our commitment to peer review through a program which will meet the desires of Illinois physicians—not the dictates of Washington bureaucrats.

The course your state medical society will follow in future months will be decided by your delegates during the special House session. County medical societies already have been urged to prepare delegates to express the viewpoints of their constituents.

PSRO in its present form is a threat to the strength and vitality of organized medicine and we must meet this threat with the force of a unified profession. The federal government apparently is attempting to fragment the medical profession in Illinois—as well as throughout the nation—thus enabling brigades of bureaucrats to deal with smaller groups of physicians which lack the strength to successfully resist. How has this come about? Many of our physicians, even at this late date, are not aware of the potential perils posed by PSRO; many misunderstand the law; and still others, thankfully few in number, see it as a means to their own ends.

Since government has played its hand, the absolute need for unity is greater now than ever before. The way to attain that unity is to correct, during the House session, any cause of disunity which may exist. It is time for vigorous opposition to government encroachment and a firm commitment to the position adopted by our house.

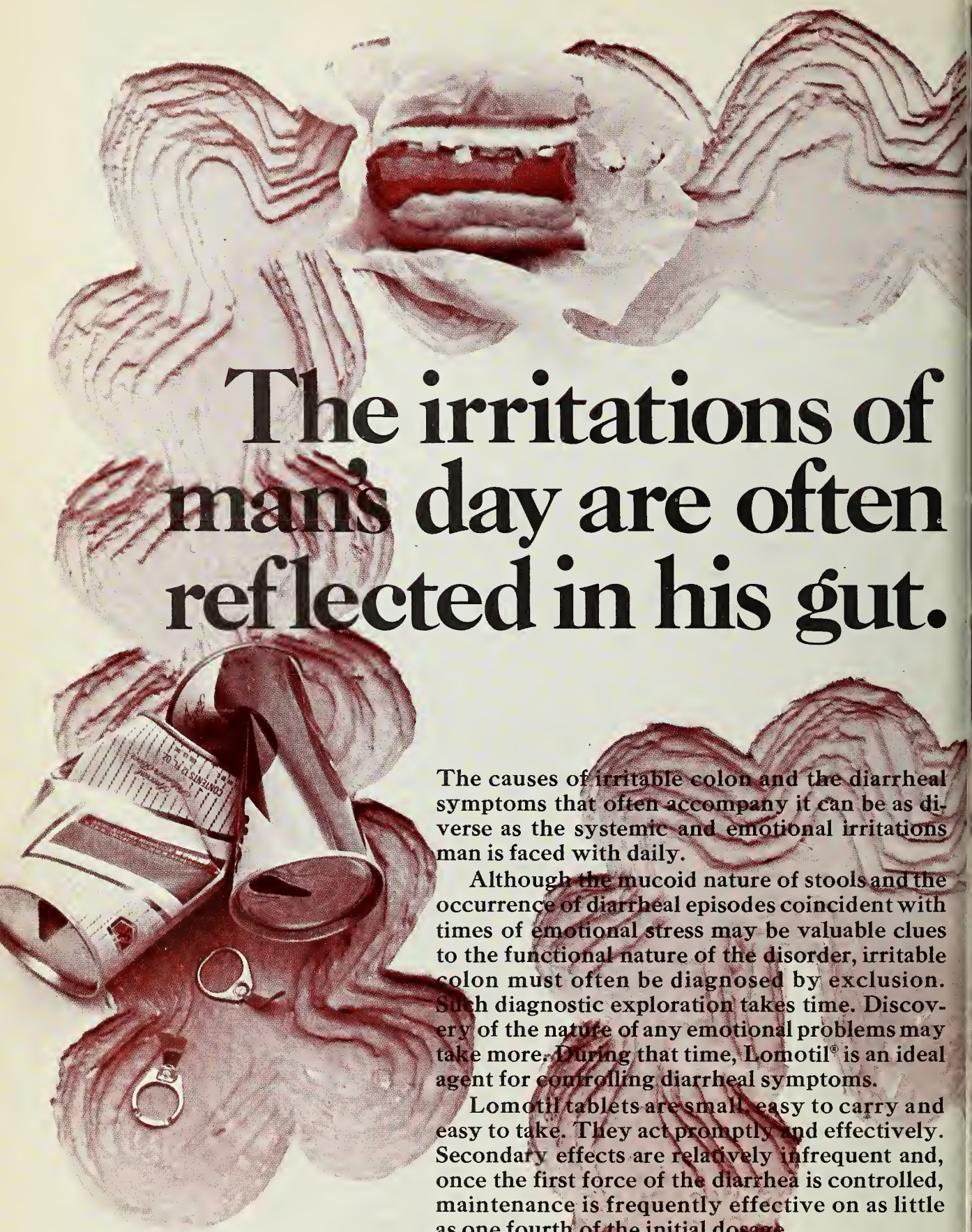
ISMS has shown that Illinois medicine is not opposed to cooperating with government programs. We demonstrated our willingness to cooperate with the state government-funded Hospital Admissions and Surveillance Program (HASP) which is directed by physicians. Our objection—and we object vigorously—is to government restrictions and regulations which compromise our best interests and those of our patients and ignore the experience of physicians who are in the best position to develop review programs based upon local need.

Washington apparently has ignored the achievements of HASP and its potential for meaningful peer review. Hopefully, government —as it attempts to implement PSRO—will discover, before it is too late, a way to avoid many of the glaring failures of its other programs in the health field.

Medicare, for instance, has been characterized

(Continued on page 155)

Unity + Strength = Effectiveness



The irritations of man's day are often reflected in his gut.

The causes of irritable colon and the diarrheal symptoms that often accompany it can be as diverse as the systemic and emotional irritations man is faced with daily.

Although the mucoid nature of stools and the occurrence of diarrheal episodes coincident with times of emotional stress may be valuable clues to the functional nature of the disorder, irritable colon must often be diagnosed by exclusion. Such diagnostic exploration takes time. Discovery of the nature of any emotional problems may take more. During that time, Lomotil® is an ideal agent for controlling diarrheal symptoms.

Lomotil tablets are small, easy to carry and easy to take. They act promptly and effectively. Secondary effects are relatively infrequent and, once the first force of the diarrhea is controlled, maintenance is frequently effective on as little as one fourth of the initial dosage.

These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.

CLEAR THE TRACT WITH THE ROBITUSSIN® LINE

The coughing season is here again. Time to rely on the four Robitussins and Cough Calmers to help clear the lower respiratory tract. All contain glyceryl guaiacolate, the efficient expectorant that works systemically to help increase the output of lower respiratory tract fluid. The enhanced flow of less viscid secretions soothes the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise. Available on your prescription or recommendation.

For coughs of colds and "flu"

ROBITUSSIN®

Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs

ROBITUSSIN A-C® ℞

Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Codeine phosphate 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control

ROBITUSSIN-DM®

Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Dextromethorphan hydrobromide 15 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"

COUGH CALMERS®

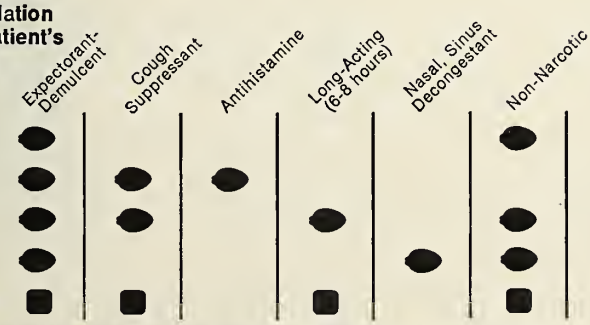
Each Cough Calmer contains:
Glyceryl guaiacolate 50 mg.
Dextromethorphan hydrobromide 7.5 mg.

Relieves cough, clears sinuses and nasal passages—keeps them "drip-dry" but not bone dry

ROBITUSSIN-PE®

Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Phenylephrine hydrochloride 10 mg.
Alcohol, 1.4%

the Robitussin® -Tract" Formulation Treats Your Patient's idual Coughing s:



handy chart as a guide in selecting the formula that provides the benefits you want for your patient.

A·H·ROBINS

A. H. Robins Company, Richmond, Virginia 23220

Clinics for Crippled Children Listed for March

Thirty clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 23 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

March 5 Alton—Alton Memorial Hospital
March 5 Carmi—Carmi Township Hospital
March 6 Hinsdale—Hinsdale Sanitarium
March 7 Sterling—Sterling Community Hospital
March 7 Effingham—St. Anthony Memorial Hospital
March 7 Lake County Cardiac—Victory Memorial
March 8 Chicago Heights Cardiac—East Chicago Heights Community Center, Inc.
March 11 Peoria Cardiac—St. Francis Children's Hospital
March 12 Peoria—St. Francis Children's
March 12 Carrollton—Boyd Memorial Hospital
March 12 East St. Louis—Christian Welfare Hospital
March 13 Champaign-Urbana—McKinley Hospital
March 13 Joliet—St. Joseph's Hospital
March 14 Springfield—St. John's Hospital
March 14 Macomb—McDonough District Hospital
March 19 Belleville—St. Elizabeth's Hospital
March 19 Rock Island—Moline Public Hospital
March 19 Decatur—Decatur Memorial Hospital
March 20 Rockford—St. Anthony Hospital
March 20 Jacksonville—Norris Hospital
March 20 Evergreen Park—Little Company of Mary Hospital
March 21 West Frankfort—Union Hospital
March 21 Elmhurst Cardiac—Memorial Hospital of Dupage County
March 22 Chicago Heights Cardiac—East Chicago Heights Community Center, Inc.
March 25 Peoria Cardiac—St. Francis Children's Hospital
March 26 Peoria—St. Francis Children's
March 27 Centralia—St. Mary's Hospital
March 27 Springfield Ped-Neurology—Diocesan Center
March 27 Chicago Heights—East Chicago Heights Community Center, Inc.
March 27 Elgin—Sherman Hospital

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.

WC **WARNER/CHILCOTT**
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

PR-GP-31-B/W

IMJ
Illinois Medical Journal
Vol. 145, No. 2, February, 1974

Adult Endocardial Fibroelastosis Following Electric Shock

By Efren C. Naguit, M.D. and Herbert Dexheimer, M.D./Belleville

Himelfarb and Weinberg from Johns Hopkins in 1943 first used the term endocardial fibroelastosis to describe that condition of cardiomegaly in infants where the pathologic lesion consisted of varying degrees of proliferation of the fibrous and elastic tissue of the endocardium of the left ventricle. It has been since recognized that there are two forms of endocardial fibroelastosis, and that it affects infants, children and adults in varying degrees.

The first group comprises the so called "primary" endocardial fibroelastosis wherein the fibroelastic proliferation of the left ventricular endocardium is not associated with any form of cardiac anomalies or defects. The second group comprises the "secondary" endocardial fibroelastosis, wherein abnormalities of the left heart are found, such as aortic stenosis, coarctation of the aorta, anomalous left coronary artery and hypoplastic aorta. The resulting pathology often is considered to be secondary to the associated cardiac defect.





EFREN C. NAGUIT, M.D., a family physician, is affiliated with St. Elizabeth Haspital and Memarial Haspital, Belleville. He received his medical degree fram the University af St. Tamas, Philippines.

HERBERT P. DEXHEIMER, M.D., Belleville, maintains a private practice in internal medicine. He is active in the Illinais State Medical Saciety and serves as Trustee far the 10th District. Dr. Dexheimer graduated fram Narthwestern University Medical Schaal.

Primary endocardial fibroelastosis is considered to be the leading cause of cardiac failure in children between ages of one and two years. Moller and Associates in 47 cases have noted the following characteristic features in children, namely:

1. appearance of congestive heart failure
2. absence of organic heart murmurs
3. onset of symptoms in the first eight months of life (85%) and very rarely after one and one-half years.
4. abnormal increase in volume of R in V_6, QS in V_3 and V_1, or both together
5. flat or inverted T wave in V_6
6. a Q wave in V_6
7. positive mumps antigen skin test in first two years of life

From the years 1930 to 1955, Thomas et al., from Massachusetts General Hospital in Boston, reviewed 10,000 autopsies on heart disease of obscure etiology and found only 20 cases of primary fibroelastosis. Of these twenty cases, four were of the infantile type (under two years), four of the childhood type (2-16 years) and 12 of the adult type (over 16 years). The oldest in the series was 71 years of age.

The cases of the adult type of primary endocardial elastosis presented a controversial and puzzling group. In some cases, it was generalized like the infant and childhood type, and in others it was less severe and tended to be patchy in distribution. Mural thrombosis was a prominent feature in 50% of the cases. The average duration of symptoms was much longer than the two other groups and chronic congestive heart failure

was a prominent feature. There also was a higher percentage of embolization in the adult type.

The congenital etiology of the adult type is questionable, mainly on the basis of the time lag between birth and the onset of symptoms. Smith and Furth considered several cases of adult fibroelastosis as examples of atypical beriberi. Clinically, the diagnosis of beriberi heart disease was based on the history of dietary deficiencies together with a dramatic response to specific therapy. Saphir has entertained the possibility that the adult type represented the end stages of some obscure infection because he has repeatedly demonstrated that myocarditis is an integral part of many forms of infectious diseases. In 1948, Davies demonstrated a rare form of heart disease prevalent among natives of East Africa clinically similar to fibroelastosis. He called this entity East Africa Endomyocardial Necrosis. However, pathologically they are entirely distinct from each other. Becker, et al, in 1953 reported 40 cases of endocardial sclerosis which he attributed to a form of diffuse "collagen" disease. Complete histochemical and morphologic studies reveal these cases to be identical to the East African Endomyocardial Necrosis, and it is believed that this entity is a new form of collagen disease.

It is, therefore, evident that the etiology of primary adult endocardial fibroelastosis is still obscure and that innumerable physical causes and disease processes may trigger its onset. We are now presenting a case in which we believed electric shock was a precipitating factor in a case of primary endocardial fibroelastosis.

Case Report

A 27-year-old married male was admitted through emergency room by ambulance on June 8, 1968, at 3:15 p.m. with a history of having come in contact with a high tension wire while putting up a television antenna in a private home. When seen he was awake and alert and vital signs were within normal limits. However, he presented 3rd degree electrical burns on plantar aspects of both feet, left anterior chest wall, right thigh and back. Past history revealed usual childhood illnesses. He previously was hospitalized in the same hospital in February, 1967, for degenerative osteoarthritis, cervical spine with associated cervical root compression syndrome with full recovery. No serious medical illnesses or previous surgeries. There was no family history of heart disease, cancer or diabetes.

Hospital course: The laboratory work up reveals Hgb 15.7 gms; normal RBC count, WBC 14,800 with 86 segs, 13 lymphs and 1 eosinophil. Urinalysis was within normal limits. Chest X-ray was read as negative. The SGOT value done on the day of admission was 15 units with subsequent values of 12 units on June 17, 16 units on June 20, and 10 units on June 25. Serum electrolytes revealed serum sodium 141 meq; potassium 4.6 meq and chloride 105 meq. The EKG findings reveal that a tracing done on the day of admission revealed myocardial ischemic changes consisting of depression of ST segments in II, III, and T wave inversion in III and AVF. An EKG done on June 11 revealed posterior myocardial ischemia with progressive changes. It was noted at this time that the T's in II, III and AVF were more deeply inverted with corresponding ST depression. An EKG on June 17 revealed ST changes suggestive of ischemia. The June 20 EKG revealed progressive changes with the addition of T wave inversion in V-leads. On June 24 the EKG was read as posterolateral myocardial disease improved from last tracing and the last tracing done July 8 was interpreted as posterolateral myocardial disease with no changes. At this time it is to be noted that T wave inversion is persistently present in leads II, III, AVF and V_5 and V_6. The patient's course in the hospital was uneventful. His heart was not enlarged to percussion and no valvular findings were noted. Blood pressure varied from 120/76 to 108/72 and no arrythmias developed. He complained of intermittent precordial pain not related to exertion or body movements or anxiety, and he was placed on Peritrate 20 mgm. T.I.D. with good results. This medication was discontinued on July 2 because of the cessation of pain.

For his multiple 3rd degree electrical burns, he was seen and treated by the plastic surgeon, who did two procedures on him. They consisted of debridement of burns of back and both feet on June 19, and skin grafting to burns was done a week later. The post-operative was uneventful and patient was discharged on July 20 as recovered.

The patient resumed his normal occupation, which was that of a mobile home salesman and did very well. He was treated for slight iron deficiency anemia in 1969. Otherwise the patient was symptom-free until September 21, 1971, when he was seen in the office with complaints of chills, fever and occasional chest pain with nonproductive cough. Examination at this time revealed an acute bronchitis. He was treated correspondingly with antibiotics orally and anti-

tussive drugs. However, he started complaining of fullness over the right upper quadrant, marked anorexia and weakness a week later, with increasing severity of the symptoms, and as a result he was hospitalized on September 28.

The laboratory findings at this time revealed Hgb 15.4 gms; hematocrit 46%; WBC 11,000 with 75 segs, 16 lymphs, 7 monos, 1 baso and 1 eso. Urinalysis was essentially normal except for a trace of albumin. His enzyme values were SGOT 515, LDH 270; Alkaline Phosphatase 55. His total proteins were 5.5 grams with normal A/G ratio. Serum cholesterol 98 mgms, uric acid 12.5 mgms, BUN 28 and fasting blood sugar 82 mgms. The serum electrolytes revealed sodium 137 meq; potassium 5 meq, CO_2-29 meq, and chlorides 106 meq. The sedimentation rate was 3 and cephalin flocculation was 3+ in 48 hours.

Initial EKG tracing on September 29 revealed ST depression in I, II, AVL, V_5 and V_6 and tall R in V_5 and V_6, which was interpreted as left ventricular hypertrophy, and ST-T changes probably due to hypertrophy and/or ischemia. Repeat EKG's on October 2 and 5 revealed no significant changes.

A chest film was done on September 30 and read as cardiomegaly and pulmonary congestion with pleural fluid on the right. Pericardial effusion could not be ruled out. A cardiac fluoroscopy was done on October 2 and interpreted as cardiomegaly with diminution of cardiac pulsations. A cardiac scan was done on October 6 and read as follows. The cardiac pool appears larger than normal with apparent disparity between cardiac size and the cardiac pool; the possibility of pericardial effusion is strongly suspected. His hospital course was stormy. Congestive heart failure set in two days after admission with signs of acute pulmonary edema and chronic passive congestion of liver. Cardiac size also was noted to increase progressively, masking the heart sounds. Still, no heart murmur or arrhythmias were noted. He was markedly anorexic and had intermittent bouts of emesis. He was treated with digitalis IV and orally together with diuretics by mouth and parenterally.

A pericardiocentesis was done on October 7th and 200cc bloody fluid was removed. Initially after the procedure, the patient felt somewhat improved, but two hours later he became cold, clammy and profusely sweating. His blood pressure dropped to 80/40 and he was transferred to the intensive care unit. The cardiac monitor was taped to his chest and revealed ventricular fibrillation. Attempts at defibrillation, external cardiac massage and intracardiac administration of epinephrine was of no avail. He expired the same day.

Post-Mortum Examination

A post-mortum examination was done and revealed myocardial hypertrophy consistent with an adult form of endocardial fibroelastosis. There also was noted a hemopericardium of approximately 85cc and chronic passive congestion of liver, kidneys and spleen. The lungs revealed acute pulmonary congestion and chronic bronchitis. The gross cardiac findings revealed heart to weigh 545 grams. The above mentioned hemopericardium is again noted. On the pericardial aspect of this area there was a puncture wound present measuring up to 2 mm. Underlying this area of hemorrhage of the pericardial tissue were two small stomas, one measuring 4 x 2 mm. and the other measuring 1 x 1 mm, which were surrounded by zones of hemorrhage which were dark red in color. The hemorrhagic area extended for approximately 2 mm. from each of the stomas. Probing the latter of the two stomas the probe passed with ease into the right ventricular cavity. Noted on pericardial surface in other areas near the apex were small punctate areas of hemorrhagic discoloration. The muscle of the pericardium circumscribing the two described stomas appeared to be somewhat softened. The left ventricular wall was thickened and measured up to 1½ cm. below the aortic valve. The endocardium of the left ventricle had a shiny gray-white appearance through most areas, even covering the papillary muscles. The myocardial muscle otherwise was not remarkable.

The mitral, pneumonic, aortic and bicuspid valves were essentially normal in appearance. Sections of the papillary muscles showed no apparent areas of infarction. The coronary arteries were normal in appearance. The left ventricular wall was characterized by small punctate areas of gray discoloration scattered throughout the muscle.

Microscopic examination revealed prominent thickening of the myocardial muscle fibers. The nuclei did have somewhat of a rectangular hyperchromatic appearance. The endocardium, in most of the sections, showed thickening with a collagenous type tissue which was demonstrated with trichrome stains. The pericardial tissue had a few scattered foci of lymphocytes and extravastated erythrocytes in the area of the grossly described stoma. Subjacent to the latter area the myocardial muscle had a pale eosinophilic ap-

(Continued on page 120)

Repeat Cesarean Section In A Low Socio-Economic Population*

By Joseph S. Dickstein, M.D., Murray C. Brown, M.D., Jack Zackler, M.D. and Stuart Abel, M.D./Chicago

Delivery of health care to the largely indigent urban minorities has long been a problem and source of much debate and controversy both in lay and medical circles. This problem is particularly acute in the area of obstetrical care and is reflected by the relatively poor record of this country, in comparison with other well developed countries.

Chicago's Board of Health Maternity and Infant Care Project 502 is one of many projects in the country designed to improve delivery of health care to the indigent of its city. In this program approximately 20,000 women a year, most of them from the lower socio-economic areas of the city, receive routine prenatal care. Complicated cases are designated high risk pregnancies, and each of these patients is referred to one of 11 teaching hospitals in the city where prenatal care in the last trimester, delivery, and post partum care are given. One such high risk category includes all patients who have had a previous cesarean section. This report is a retrospective study of the women in this category, over a three-year-period, covering maternal morbidity and fetal mortality.



Dickstein *Abel* *Brown* *Zackler*

JOSEPH S. DICKSTEIN, M.D., at the time the article was written, he was a resident in the Department af Obstetrics and Gynecology at the University af Chicaga Haspitals and Clinics. He received his medical degree fram the University of Chicago and is a junior fellow in the Americon College af Obstetricians and Gynecologists.

STUART ABEL, M.D., is Associate Professor of Obstetrics and Gynecalagy at Northwestern University Medical School, where he received his medical degree. Dr. Abel is a founding Fellow in the American College of Obstetricians and Gynecologists and is Fellaw af the American Callege of Surgeans. He is Directar of the Maternity and Infant Care Project 502 for the Chicago Baard af Health.

MURRAY C. BROWN, M.D., is the Cammissioner of Health, City af Chicaga. Dr. Brown has authored numerous scientific articles and television films under NIH gronts.

JACK ZACKLER, M.D., is Clinicol Associote Professor in Community Medicine and Professor of Obstetrics ond Gynecology at Chicago Medical School. He is attending physician at Maunt Sinoi Hospital, Chicago. A graduate of the University of Illinois College of Medicine, Dr. Zackler is certified by the American Boord of Obstetrics and Gynecology. He is a member of the Chicago Maternal ond Child Health Advisory Committee.

Material and Methods

During the period from January 1, 1966, through December 31, 1968, a total of 660 repeat cesarean sections were performed in 11 hospitals, participating in Chicago's Project 502, on patients referred from Board of Health clinics. An additional 57 other women who had had previous cesarean sections were referred from the regular Board of Health clinics for planned repeat sections. Relevant data about each pregnancy, labor, delivery, postnatal course and fetal outcome was abstracted from hospital charts.

Results

Table I summarizes the data of the 719 women in the study. The 660 patients finally included in this study had had one to six previous cesarean sections as appears in Table II.

All cesarean sections were classified as either "elective" or "emergency." There were 326 elective repeat cesarean sections and 334 emergency repeat cesarean sections.

Indications for the 334 emergency cesarean sections were labor and/or ruptured membranes in 297 cases; toxemia, preclampsia, and eclampsia in 15 cases; and third trimester bleeding in 22 cases.

Maternal Mortality and Morbidity

During the three year period of this study,

*Funded by the Local Health Services Division of the Illinois State Department of Health.

TABLE I

Total patients scheduled for repeat cesarean section (1-1-66 through 12-31-68)	719
Moved or otherwise lost for follow-up	19
Vaginal Delivery	18
Spontaneous Abortion	15
Not Pregnant	4
Ectopic Pregnancy	2
Consulted Private Physician	1
TOTAL PATIENTS	660

there were no maternal deaths among the patients undergoing repeat cesarean section.

There were a number of post-operative complications, the totals of which are summarized in Table III. The various complications encountered are presented in Table IV with a breakdown into the elective and emergency groups.

Fetal Mortality

Data on perinatal deaths are presented in Table V. There was a total of 26 perinatal deaths in the 660 sections performed. Of these deaths, 21 were in the emergency repeat group and five were in the elective repeat group.

After correcting for congenital anomalies, we find the total perinatal deaths in the elective group is only three compared to 19 in the emergency group. This gives a fetal death rate per 1000 births of 9.1 in the elective group and 57.0 in the emergency group.

Vaginal Delivery

In this study, eight patients delivered vaginally after a repeat elective cesarean had been planned. These patients entered the hospital in active, advanced labor and were allowed to deliver per vagina with careful observation. Four of this group entered with prolonged rupture of the membranes and amnionitis. Two patients were actually late abortions at 4½ months. And finally, two patients were allowed electively to deliver from below where the indications for the first section was placenta previa and conditions were favorable in early labor.

Finally, we see that in the group of 18 women with vaginal deliveries after previous section, the maternal outcome was favorable in all instances.

Discussion

Our data indicates that those patients undergoing elective repeat section have significantly lower post operative complications than a group of emergency repeat sections. Because of vast differences in criteria used in defining the nature of post-operative complications in the various series reported in the literature, no attempt has been made to compare our data with others.

The results in our series regarding perinatal mortality are even more interesting. The hazards of premature labor, toxemia and hemorrhage have contributed to a fetal wastage in the emergency group nearly seven times more than in the elective group.

We analyzed each perinatal death in the elective group individually from the original hospital charts. Of the five perinatal deaths, two were severe congenital anomalies not compatible with life, two were severe erythroblastosis fetalis,

TABLE II

Number of Previous Cesarean Sections	Number of Patients	Per-Cent of Patients
1	430	65.15
2	166	25.01
3	39	5.91
4	22	3.33
5	2	.30
6	1	.15
TOTAL	660	100.00

TABLE III

Total Elective Cases	Total Emergency Cases
326	334
Total cases with complications	Total cases with complications
61	82
Total complications	Total complications
69	94
Per cent complicated cases	Per cent complicated cases
18.71	24.55

This difference in percentage is significant ($p < .05$ respectively)

TABLE IV

	Elective		Emergency	
Complications	No.	%	No.	%
Infections	57	17.5	72	21.5
Errors of surgical technique	7	2.1	5	1.5
Cardiovascular	4	1.2	5	1.5
Postoperative hemorrhage	1	0.3	5	1.5
Uterine Rupture	0		5	1.5
Hypofibrinogenemia	0		1	0.3
Convulsions	0		1	0.3
TOTAL	69		94	

TABLE V

Cause of Death	Elective Repeat	Emergency Repeat
Cerebral Hemorrhage	0	1
Congenital Heart Disease	1	0
Respiratory Distress Syndrome	1	4
Intra Uterine Anoxia	0	6
Erythoblastosis Fetalis	2	0
Anencephaly	1	0
Prematurity	0	3
Achondroplasia	0	1
None given	0	4
TOTALS	5	21
Corrected for Congenital Anomalies	3	19
Corrected for birth weight under 1000 gms.		1
Corrected death rate for Anomalies per 1000 births	9.1	57

[difference significant $p < .01$ (two tailed T test)]

and one was a death attributed to respiratory distress syndrome.

We have corrected our total of five to a total of three (excluding the congenital anomalies), although it might be argued fairly that only one of these babies was truly "salvageable".

In Table VI we have compared our figures for corrected perinatal death rate (excluding anomalies) to several other large series of elective repeat sections in the recent literature.

Conclusion

When repeat cesarean section is performed on an elective basis, both maternal morbidity and fetal mortality are greatly improved, as compared to when some factor necessitates a non-elective or emergency abdominal delivery. ◄

TABLE VI

Author and Date	Elective Sections	Corrected Deaths per 1000 Births	Reported From
Chicago Project 502, 1970	326	9.1	City of Chicago High Risk Program
Sohlberg, 1967	929*	3	Sanford
Epstein, 1963	991	28	Mt. Sinai, New York
Bryant, 1961	1,879	7	9 yr. study in 9 hospitals—Cincinnati
Schwartz, 1959	580	11.7	Jewish Hospital Brooklyn

References

1. Zackler, Jack, S. L. Andelman and F. Bauer. "The Young Adolescent as an Obstetric Risk." *Am. J. OB-GYN.* 103:305-312, 1969.
2. Sohlberg, O. S., et al. "Impact of prior Labor in Cesarean Section Morbilaty." *Pacific Medical Surgery* 7554-6, 1967.
3. Epstein, W. A. "Repeat Cesarean Section—A Report of 1028 Cases." *Journal of the Mt. Sinai Hospital,* New York, 30:401-414, 1963.
4. Schwartz, R. M., et al. "Perinatal Mortality in Repeat Cesarean Section." *OB-GYN.* 14:773, 1959.
5. Bryant, R. D. "Cesarean Section in Cincinnati, Ohio," 1950-1959. *Am. J. OB-GYN.* 81:480, 1961.

Adult Endocardial Fibroelastosis Following Electric Shock

(Continued from page 117)

pearance, but otherwise was not remarkable.

Discussion

The electrocardiographic findings in this case were of unusual interest because of the findings of marked myocardial ischemia with no corresponding elevation in the serum enzymes even when taken serially. It is then the expressed opinion of the authors that these EKG changes were a direct result of myocardial injury secondary to physical agents, which in this case was severe electrical shock. ◄

References

A complete bibliography for "Adult Endocardial Fibroelastosis" may be obtained by writing the *Illinois Medical Journal,* 360 N. Michigan Ave., Chicago, 60601.

Thymoma, Erythroid Hypoplasia and Myasthenia Gravis

Report of a Case With Ultrastructural Study*

By Balbino B. Fernandez, M.D. and Charles Hartman, M.D./Park Ridge

A case of thymoma associated with erythroid hypoplasia and myasthenia gravis is presented. The thymoma was of the mixed lymphocytic and epithelial cell type. Improvement of the anemia after complete excision of the tumor was evidenced by elevated reticulocyte counts. Ultrastructurally the tumor showed a uniform picture of lymphocytes intermixed with epithelial reticulum cells, the latter with numerous desmosomes and cytoplasmic fibrils. No secretory granules were observed. A comparison is made with previously reported cases of thymomas associated with myasthenia gravis and those attendant with the secretion of ACTH.



BALBINO B. FERNANDEZ, M.D., is Associate Pathologist at Lutheran General Hospital, Park Ridge and Clinical Instructor of Pathology at the University of Illinois, Chicago. Dr. Fernandez received his medical degree from the University of Madrid, Spain and is Board Certified in Anatomical and Clinical Pathology.

CHARLES HARTMAN, M.D., is attending physicion, Department of Medicine at Lutheran General Haspital, Park Ridge.

The association of a thymic tumor and anemia was first described in 1928. Since that time about 80 cases have been reported in the literature. Reviewing the world literature, Hirst, et al.[1] collected 36 cases of thymoma associated with erythroid hypoplasia. Only ten exhibited the triad of thymoma, anemia and myasthenia gravis. The purpose of this paper is to report a case of the triad with ultrastructural studies of the thymic neoplasm. We believe this to be the first electron microscopic study of a thymoma associated with erythroid hypoplasia and myasthenia gravis.

Case Report

The patient, a 47-year-old white female, was first seen on 6/22/66 complaining of difficulty in swallowing for the previous three weeks. She also noticed that her speech was slurred. Her past and family history were non-contributory. Her physical examination was within normal limits. It was felt that she was experiencing cardiospasm on a functional basis and atropine was prescribed without improvement. Esophagogram, BMR, ECG and T_3 determinations were all normal. Prostigmine bromide 30 gm. per day was started on 7/14, and was followed by a marked improvement. She did well for several years and was seen again on 2/24/70 with a history of increasing fatigue, chest pain, and heaviness in the chest after mild exercise; these symptoms were relieved by rest. On physical examination her pulse was 104 per minute and B.P. 136/80 mm/Hg. A sys-

*This study was supported by the Park Ridge United Fund, Park Ridge, Ill.

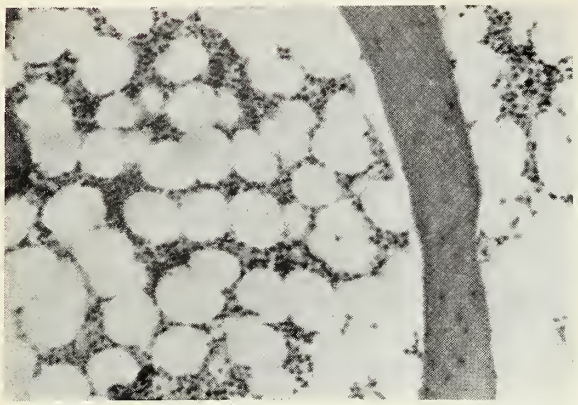


Figure 1. Bone marrow. Hypoplastic marrow, cells represent mostly elements of the granulocytic series. Hematoxylin and eosin.

tolic murmur was heard at the apex. She was admitted to the hospital on 2/27/70. Her admission hemogram showed a hemoglobin of 3.2 gm% and hematocrit of 10.5%, WBC 7800 with 45 polys, 4 bands, 50 lymph and 1 mono. Retriculocyte count was 0.2% and platelets 135,000 per cmm. Protein electrophoresis showed a minimal decrease of alpha$_1$ globulin. Direct Coomb's test was weakly positive. Fragility test was within normal limits. Other clinical laboratory tests as well as X-rays of the chest and upper gastrointestinal tract were normal. A bone marrow aspiration was performed but the results were those of a dry tap. An iliac crest biopsy was performed (Fig. 1) and the marrow was moderately hypocellular with marked depression of the erythroid elements. The granulocytic elements were represented by metamyelocytes, bands and segmented forms. Focal aggregates of small lymphocytes were present. Megakaryocytes were diminished. She received seven units of packed erythrocytes and was discharged on 3/17 with 13.6 gm% of hemoglobin, 40.2% hematocrit, 4.2 million RBC's and 8300 WBC's with a normal differential.

She was readmitted a week later with aggravation of the myasthenia gravis. At that time hematocrit was 35.7% and hemoglobin of 11.1%. Chest X-rays were negative. She received three units of packed erythrocytes and was discharged on 4/7 with a normal blood picture and the myasthenia under control. On 4/16 she presented with severe dyspnea and large amounts of bronchial secretions. This time her dose of Prostigmine had to be increased from 45 mg. to 135 mg. per day before the myasthenia could be brought under control. Her RBC's had dropped to 3.7 million per cmm and the hemoglobin to 11.5 mg%.

Because of the persistency of the anemia and the worsening of the myasthenia, it was decided to perform a surgical exploration of the anterior mediastinum despite the negative radiographic findings which included laminography of this area.

She underwent a thoracotomy on 5/6. A mass was found in the left side of the anterior mediastinum, it extended upward to the cupola of the left pleural cavity. The tumor was encapsulated and was removed intact. On the fourth post-operative day she developed pneumonia and there was a drop in hemoglobin, hematocrit and RBC's. Her myasthenia gravis worsened. She was unable to breath for any long period of time without mechanical assistance. She developed episodes of aspiration and a tracheoesophageal fistula and expired on the 40th post-operative day. Her blood picture had improved after surgery with steady increases in the reticulocyte count which at the time of death was 4.5%. No autopsy authorization was obtained.

Pathology Report

Gross: The specimen consisted of an irregularly pyramidal, bosselated firm tumor (Fig. 2), measuring 5.0 x 3.5 x 2.0 cm. and weighing 35 gm. It was completely surrounded by a thin fibroconnective capsule. Its cut surface was divided into irregular tan nodules by thick bands of dense fibroconnective tissue.

Microscopic: The tumor was composed of two cellular elements (Fige. 3). The first was represented by a large cell with a moderate amount of pale eosinophilic cytoplasm. The cytoplasmic margin was poorly defined. The nuclei were ovoid, large and contained prominent acidophilic nucleoli. The second cell consisted of small lymphocytes with scanty cytoplasm and dense hyperchromatic nuclei. Rare mitotic figures were observed in the larger cells. Although most of the tumor exhibited an admixture of these two

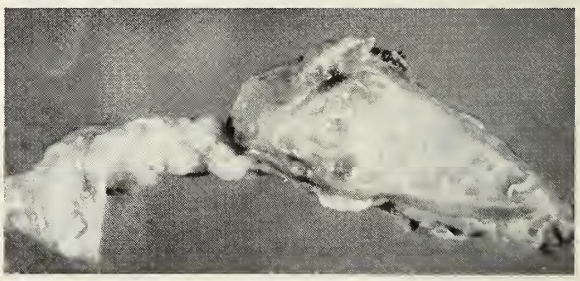


Figure 2. Cut surface of the tumor showing coarse nodules separated by thick bands of fibrous tissue. The tumor has attached lipomatous tissue that contained remnants of the thymus gland.

elements in approximately equal numbers, in some areas the large cells predominated. There was no evidence of capsular invasion.

Electron Microscopic Study: Electron microscopic examination demonstrated the two cellular components observed with light microscopy (Fig. 4). The lymphocytes had a large nucleus with dense chromatin located alongside the nuclear membrane as well as centrally. The cytoplasm was scanty and contained a few mitochondria occasionally arranged in clusters at one pole of the cell (Fig. 5), scattered free ribosomes and a few vesicles of smooth endoplasmic reticulum. The epithelial cells generally had a large nucleus with finely dispersed chromatin slightly denser along the nuclear envelope and a large nucleolus. Occasional cells, however, contained a nucleus with compact chromatin dispersed throughout the nuclear matrix as well as lined along the nuclear membrane. The contour of the nucleus was irregular with multiple indentations (Fig. 4). Large numbers of free ribosomes were dispersed in the cytoplasm, as were mitochondria, cisternae of both smooth and rough endoplasmic reticulum and vesicles of the Golgi apparatus. In many cells bundles of fine tonofibrils traversed the cytoplasm and in several instances appeared to be attached to the desmosomes. The cell membranes were smooth and exhibited many desmosomal attachments (Fig. 7). No evidence of secretory granules was present in either the epithelial or lymphocytic cells.

Discussion

The association of thymomas with other clinical syndromes is well established. Numerous cases of this tumor associated with myasthenia gravis, erythroid hypoplasia or aplasia,[1-4] Cushing's syndrome,[5] agammaglobulinemia,[3,6] and cancer[6,7] have been reported.

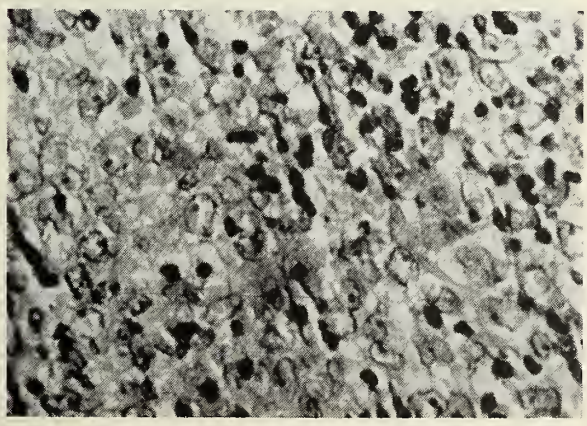


Figure 3. Light microphotograph. Section of the tumor showing an admixture of lymphocytes and large reticulum cells. Hematoxylin and eosin.

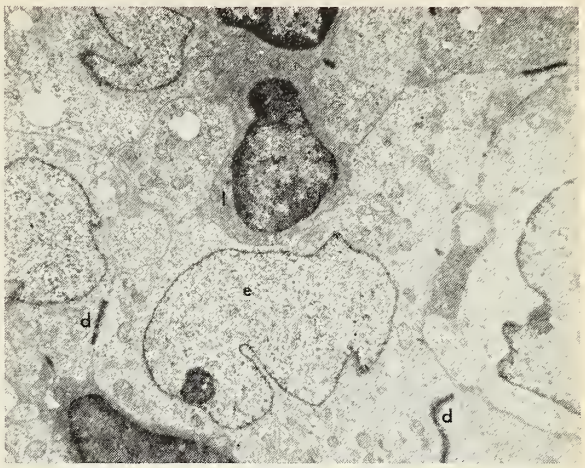


Figure 4. Lymphocyte (l) exhibiting small nucleus with dense chromatin. The epithelial reticulum cell (e) shows a large vesicular nucleus with large nucleolus. Many desmosomes (d) are present between the reticulum cells.

Recently a case of granulomatous thymoma and erythroid hypoplasia has been observed.[8] Since the first report of the association of thymoma and erythroid hypoplasia was made by Matras and Priesel in 1928, increasing numbers of cases have been documented. In a thorough review of the literature on the subject of erythroblastopenic anemia and thymoma[1] only ten cases of the triad represented by thymoma, erythroid hypoplasia and myasthenia gravis were found. In two-thirds of these cases the thymoma was of spindle cell type, in 15% a mixed epithelial and lymphocytic type was present. The pathogenesis of the erythroid hyperplasia has not been definitely established, however, its association with hypogammaglobulinemia, myasthenia gravis and autoimmune hemolytic anemia strongly suggests an autoimmune mechanism.[2,3] In the present case a weakly positive Coomb's test was obtained only during her first hospitalization. In cases of erythoid hypoplasia and anemia, resection of the tumor appeared to be the method of choice for treatment; about 15% of cases show total regression of the anemia.[1,2,8] In our case, although no postoperative bone marrow studies were performed and a post-mortem examination was refused, it was felt that the steady increase of the reticulocyte count was evidence of good response.

Histologically two principal cells are present in the normal thymus: the lymphocyte and the reticular epithelial cells.[9] The latter is believed to be of endodermal origin. The origin of lym-

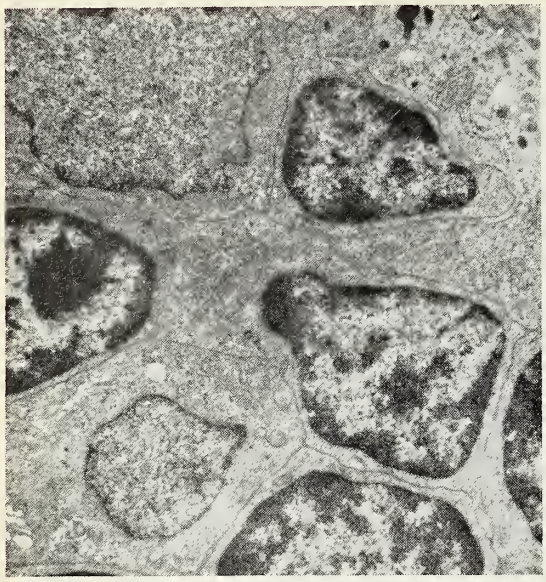


Figure 5. Cluster of lymphocytes showing grouping of organelles at one pole of the cell.

phocytes from mesenchymal elements has been challenged, although different studies have been performed no definite agreement has been reached on this subject. A third cellular element, the phagocytic reticular cell, is also present; these are of mesenchymal origin and are mostly located around blood vessels. Ultrastructural studies of normal thymuses and thymomas have failed to show differences in the lymphocytic elements of the tumor as compared to those of the normal gland.[6,10,11]

It is of interest that, in most thymomas on which ulstrastructural studies have been done,[10-12] differences have been observed in the general architecture of the cells, mostly regarding nuclear structure and the presence of desmosomes and tonofibrils. The reticular elements of our case contained large nuclei with variation in the condensation of chromatin, large nucleoli and the presence of conspicuous tonofibrils and large numbers of desmosomes. Previous reports have established that the epithelial reticular cells and lymphocytes are the cellular elements involved in the thymoma.[11] The difference between the two types of reticulum cells present in the thymus is based on the presence of tonofibrils and particularly desmosomal attachments. The mesenchymal reticulum cell lacks both of them. Although a case of so-called granulomatous or Hodgkin's-like thymoma has been recently reported,[8] no ultrastructural studies are available. These will be of interest to investigate to what extent the mesenchymal elements participate in the architecture of this tumor.

The presence of secretory granules in the epithelial cells of the thymus is a prominent and interesting feature.[9-11] Kay[10] reported a case of an ACTH secreting thymoma in which abundant electron dense, membrane bound, secretory granules were present. Posteriorly he reported three more cases of thymic lesions, two thymomas, one of them associated with myasthenia gravis and a case of thymic hyperplasia with myasthenia, none of which had secretory granules. In our case examination of multiple areas did not reveal evidence of secretory granules in either epithelial reticulum cells or lymphocytes. It appears that in the process of development of thymic tumor these granules are lost with exception of those cases associated with ACTH secreting tumors.

(Continued on page 146)

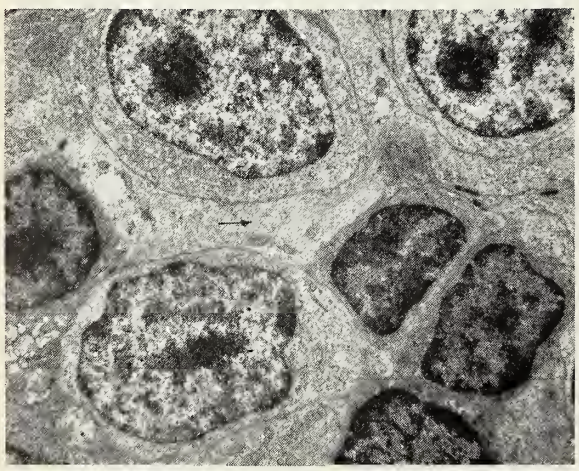


Figure 6. Bundles of cytoplasmic fibers (arrow) in the cytoplasm of reticulum cells.



Figure 7. Prominent desmosal attachments (d) between epithelial cells. A cluster of cytoplasmic fibers (arrow) appears to be attached to one of the desmosomes.

Meckel's Diverticulum

By Kelly M. Berkley, M.D., F.A.C.S./Mt. Vernon

Hundreds of articles on Meckel's diverticulum have been published since its first full anatomical and embryological description by Johann Frederick Meckel in 1814, yet there is no evidence that prophylactic removal of the Meckel's diverticulum can be accomplished without increasing morbidity and mortality. Secondly, evidence is lacking that removal of a diverticulum, thought to be the cause of chronic abdominal pain, is beneficial. In an attempt to answer these questions 51 cases operated on at the Holzer Hospital, Gallipolis, Ohio, from 1948 to 1968 were reviewed. Fifty cases of abdominal hysterectomy were also reviewed for comparison.

A case of Meckel's diverticulum diagnosed preoperatively is herein reported, since a definitive diagnosis is rarely made preoperatively, e.g. in only two of 149 patients reported by Gross et al was the roentgenographic diagnosis suggested by gastrointestinal series. Weinstein et al reported that the preoperative diagnosis was made in only nine of 722 cases.[1]

Results

Table 1 summarizes the cases, which shows 39 of the 51 cases were diagnosed incidentally at operation. Intestinal obstruction and chronic abdominal pain were the most common indication for operation.

KELLY M. BERKLEY, M.D., a tharacic and cardiavascular surgean, is affiliated with The Sauthern Illinais Clinic, Mt. Vernan.

TABLE 1

Categories of Discovery of Meckel's Diverticulum Holzer Hospital 1948-1968

Incidental at operation	39
Inflammation	1
Chronic abdominal pain	4
Intestinal obstruction	4
Hemorrhage	3
TOTAL	51

Table 2 shows the number of patients operated on for specific indications, showing mortality, morbidity, average length of hospital stay and long term follow-up. As is expected, the long term follow-up, when the indications for surgery are hemorrhage, inflammation, or obstruction, is excellent.

Two of the four patients were relieved of chronic abdominal pain by diverticulectomy at the second year follow-up examination and one at the one year interval. One patient was not relieved. In that patient a subsequent diagnosis of severe psychoneurosis was made.

Table 3 shows the number of Meckel's diverticulum incidentally removed at operation when the primary disease concerned the stomach or duodenum, gallbladder, appendix, intestine, reproductive system, or miscellaneous. The mortality, complications, and average length of hospital stay is shown.

TABLE 2

Summary of the Specific Indications for Surgery of Patients found to have a Meckel's Diverticulum

Indication	No. of Pts.	Mortality	Morbidity			Length of Stay (Days)	Long Term Follow-up		
			Pulmonary	Peritonitis	Early Postop. Obstruction		Free of Symptoms*	Unknown	Unrelieved
Hemorrhage	3	0				8.7	2 (5)	1	
Inflammation	1	0				8.0	1 (3)		
Obstruction	4	0		1	1	10.8	3 (5)		
Chronic Abdominal Pain	4	0	1			7.0	2 (2) 1 (1)	1	1

The figure in parenthesis denotes the length of the follow-up period.

Table 3

Meckel's Diverticulum Incidentally Discovered at Operation

Primary Organ Or System	No. of Pts.	Mortality	Complications					Average Length Of Hospital Stay (Days)
			Pulmonary	Wound Infection	Urinary Tract Infection	Fever Unknown Origin	Hemorrhage	
Gastroduodenal	4	0	1					12.3
Gallbladder	3	0	1		1			11.7
Appendix	4	0	1					5.3
Intestinal	2	0		1				10.0
Reprodnctive	16	0	1			1		6.6
Other	10	0		1				8.9
TOTAL	39	0	4	2	1	1		

Complication Rate 20%

It can be seen that 16 of 39 Meckel's diverticulum were removed incidentally at the time of gynecological surgery. There was no mortality. The average length of hospital stay in the hospital was 6.6 days. There were only two complications, one of the respiratory system and one a fever of unknown origin.

For purpose of comparison, 50 cases of total abdominal hysterectomy were reviewed. There was no mortality. The average length of hospital stay was 7.2 days. There were three postoperative pulmonary infections, two urinary tract infections, one fever of unknown origin, one postoperative bleeding, and one neurasthenia in an elderly patient.

On the basis of this information, it is concluded that the removal of a Meckel's diverticulum found incidentally at operation does not significantly increase the mortality, length of hospital stay or complication rate above that associated with total abdominal hysterectomy.

A case report of a patient with chronic abdominal pain follows:

Case Report

A 65-year-old white male, was seen November, 1965, at Philadelphia General Hospital, complaining of right lower quadrant abdominal pain, which had existed for over 30 years. Attacks of dull aching in the right lower quadrant occured when he lay on his right side, sometimes waking him from sleep. Change in position relieved these attacks. They were unrelated to the alimentary, genitourinary, or musculoskeletal systems.

In 1958, he underwent a partial gastrectomy with gastrojejunostomy and vagotomy. Postoperatively, symptoms remained essentially unchanged.

Physical examination showed a thin, pleasant man appearing his stated age. There was a well healed, linear, mid-line, surgical scar in the upper abdomen. The examination was otherwise normal. Laboratory findings: the hemoglobin was 13.5 grams %. Urinalysis was normal. Stool examination showed no occult blood.

A film of the abdomen on November 23, 1965, (Fig. 1) was reported as normal. No comment was made regarding the large air filled structure to the left of the second lumbar vertebrae (arrows). The barium enema, March 1965, Hospitals of the University of Pennsylvania (Fig. 2), shows an area of narrowing in the ileum. An upper gastrointestinal and small bowel roentgenographic study shows the stomach emptying through a gastroenterostomy into the jejunum. The small bowel was interpreted as normal. An air filled structure was seen in the left upper

TABLE 4

Summary of Morbidity and Mortality of Total Abdominal Hysterectomy

Primary Organ Or System	No. of Pts.	Mortality	Complications					Average Length Of Hospital Stay (Days)
			Pulmonary	Wound Infection	Urinary Tract Infection	Fever Unknown Origin	Hemorrhage	
Uterus	50	0	3	0	2	1	1	7.2

Complication Rate 14%



Fig. 1. The roentgenogram shows an air-filled structure in left upper quadrant, (Lerner's sign.)



Fig. 2. The reflux barium enema shows the diverticulum partially filled with barium.

quadrant (Fig. 1) which filled with barium on reflux into the small bowel on examination of the colon (Fig. 2).

When all information was reviewed the diagnosis of Meckel's diverticulum was made. The patient was explored through a transverse, right lower quadrant incision. A large mouthed diverticulum was excised and an appendectomy done. The postoperative course was uneventful; his pain was relieved.

Comments

In most cases described in the literature, the preoperative diagnosis was made by the antegrade examination of the gastrointestinal tract. However, in some reported instances, the diverticulum could be demonstrated by the reflux of barium into the ileum.[2] The visualization of an air filled structure on roentgenogram of the abdomen, a sign originally described by Lerner et al[3] in 1953, is also useful. In our case, these two rather infrequent roentgenographic findings established the diagnosis preoperatively.

Conclusion

1. Three of four patients operated on for chronic abdominal pain and found to have a Meckel's diverticulum were relieved of their pain.

2. In the majority of patients, 39/51, the Meckel's diverticulum was an incidental finding at operation.

3. The complication rate was 20% in those cases in which the diverticulum was removed incidentally and 14% for a series of 50 cases of hysterectomy. In the former the magnitude of the operative procedure was greater. It is, therefore, suggested that incidental removal of the diverticulum did not increase the morbidity or mortality of the planned operative procedure. ◄

References

1. Weinstein, E. C., Cain, J. C., and ReMine, W. H. "Meckel's Diverticulum, 55 Years of Clinical and Surgical Experience." *JAMA,* 182:251-253, 1962.
2. Miller, R. E., and Miller, W. J. Small Bowel Obstruction. "The Complete Reflux Small Bowel Examination." *Am. J. Surg.,* 100:572-577, 1965.
3. Lerner, H. H., Levinson, S. S., and Kateman, A. E. "Meckel's Diverticulum, A New Roentgen Diagnostic Sign and Case Report." *Am. J. Roentgen,* 69:268-271, 1953.

Pediatric Perplexities
Ruth A. Seeler, M.D., Editor

Acute Yellow Phosphorus Rat Poisoning

By Sudha Rao, M.D. and Rowine Hayes Brown, M.D., J.D./Chicago

Acute yellow phosphorus poisoning is now rare in the United State of America, compared to its incidence in earlier years. In Latin American countries, however, small epidemics tend to follow the Christmas and Independence Day celebrations, because of the phosphorus-containing firecrackers which constitute a cheap and accessible poison for suicidal purposes.[1]

In young children in the United States, however, the most common source of acute poisoning is the accidental ingestion of rodent and roach powders. These poisons, Stearn's Electric Brand Paste (3%), Patterson's Zinc Phosphide Rodent Bait (2.0%), Pearson's Rat poison (Zinc phosphide 2.0%), Rat Doom Zinc Phosphide (5%) all contain a yellow phosphorus. Although, the incidence of inorganic phosphorus poisoning is low, and thus the importance may seem slight, yellow phosphorus is a powerful protoplasmic poison and carries a high mortality rate associated with ingestion.

As rats are becoming increasingly resistant to the warfrin derivatives it may be anticipated that the yellow phosphorus rat poisons may be more widely used, and thus the toxicities seen more frequently. Our recent experience illustrates many of the difficulties encountered in caring for these desperately ill children.

Case Report

A 13-month-old Black female was transferred to the Cook County Hospital at 9:30 p.m. after she ingested an undeterminable amount of "Electric Brand Paste" containing 3% yellow phosphorus. Around 4:00 p.m. her mother noticed the child playing with the rat poison and found waxy, yellow-brown material on both hands and in the child's mouth. She washed the child's hands with water, but did not rinse out the mouth as fumes were coming from it. The child was given butter and was then taken to a local hospital within a half hour of ingestion. At the hospital, ipecac was administered and the child vomited. A gastric lavage was done, but no further material was recovered. She later vomited and the material was slightly bloody. The mother had not noted any change in the child's behavior, and she seemed unchanged five hours later when transferred to the Cook County Hospital.

Although there was no history of pica, her feeding was grossly inappropriate for age as she consumed 40-50 oz. of whole milk per day with little or no appetite for solid foods.

Examination revealed an afebrile, well-oriented child, responsive to questions, with an obvious garlic odor to her breath. Vital signs were within normal limits and she did not appear to be in any distress. The child refused to eat and intravenous fluids were begun. Three hours following admission she passed a pasty green stool which smoked and had characteristic garlic odor. Our Toxicologist, Eleanor Berman, Ph.D., identified the inorganic phosphorus in the stool.

X-ray examination of the chest was within normal limits. The child was found to have an elevated blood level at 89 micrograms per cent although X-ray examination of the long bones and the flat plate of the abdomen were negative for evidence of chronic lead ingestion.

The initial electrolytes and hematocrit were within normal limits (Table 1). The morning after admission she seemed comfortable and no longer smelled of garlic. As a precaution she was continued on intravenous fluids although all vital signs were normal. Approximately 21 hours after ingestion, her general condition began to deteriorate rapidly. The respiratory rate increased to 56 per minute, pulse 140 per minute, and fine rales were heard diffusely throughout both lung fields. X-ray examination of the chest showed diffuse haziness. The child became lethargic and difficult to arouse. Now the liver was soft, nontender, and extended 3 cm. below the right costal margin.

Therapy included the administration of oxygen, intravenous fluids, and intravenous ampicillin. The EKG showed right axis deviation, and

SUDHA RAO, M.D., is a Resident in the Department of Pediatrics at Cook County Hospital and Hektoen Institute for Medical Research. ROWINE HAYES BROWN, M.D., J.D., is the Medical Director at Cook County Hospital.

TABLE

Date	Time	Hct	BUN	Glucose	Na	K	Cl	CO_2 Comb. power	Calcium
7/24/73	10:00 pm	37%	15	100	142	3.8	100	17.2	
7/25/73	2:30 pm	40%	22	636	126	7.2	92	4.6	7.9
7/25/73	4:30 pm	38%	32	191	130	7.2	97	8.0	8.0
7/25/73	10:30 pm	38%	—	—	130	7.4	96	—	10.3

depression of the S-T segments and leads I, II, III, AVF, V4, V5 suggesting myocardial injury and also intraventricular conduction defect. By 23 hours after ingestion her condition had deteriorated further and the liver now extended 6.5 cm. below the right costal margin. She had developed edema of the eyelids and was oliguric with only 20 ml. of urine over the previous 8 hours. The BUN was increasing and she had a marked hyperglycemia (See Table). Concurrently, there was a hyponatremia and severe metabolic acidosis. Sodium bicarbonate and an increased amount of intravenous fluids were given in an attempt to correct the acidosis and improve urinary output. Intravenous steroids also were given. She passed from her semi-comatose to a fully comatose state. A catheter was placed in the bladder and some urine was obtained which showed two plus proteinuria and a few RBC's and WBC's.

She continued to deteriorate and had a cardiorespiratory arrest approximately 40 hours after ingestion. She was resuscitated several times; however, she had repeated arrests and was pronounced dead two hours later. Autopsy showed flabby, markedly dilated cardiac chambers and diffuse congestion and edema of the lungs. The liver showed a diffused yellow discoloration with extremely extensive bands of central necrosis. The central nervous system revealed a generalized cerebral edema.

Discussion

Elemental phosphorus does not occur free in nature, but as the phosphate from which it is extracted by electrolytic methods.[2] Elemental phosphorus is found in two forms. Red phosphorus is nonvolatile, insoluble, unabsorable and therefore non-toxic when taken by mouth. It has proved toxic when given intravenously, probably because of its conversion into yellow phosphorus.[3]

Yellow phosphorus is an extremely potent poison which is insoluble in water; although it diffuses through water as a vapor in the form of a dilute colloidal solution. It is soluble in fats and in bile, and therefore absorbed from the gastrointestinal tract and from subcutaneous tissues. Toxic guantities may be absorbed from the intact skin or by inhalation of phosphorus vapors. There is a characteristic garlic odor to the fumes of yellow phosphorus.[2] As little as 15 mgs of yellow phosphorus can produce symptoms.[4-5] A few milligrams of yellow phosphorus may cause death, and the lethal dose seems to be much smaller than that previously reported, namely 1 milligram per kg of body weight.[5-6]

Acute yellow phosphorus poisoning occurred frequently in the last century and during the early part of this century when phosphorus was regarded as a therapeutic panacea, and secondly, match tips of yellow phosphorus was almost universally available.[7] In 1942, the use of yellow phosphorus match tip was legislated out of existence. Today the element is not used in clinical medicine except for trace quantities as its radioactive component. The most common source of phosphorus as a poison is in the form of rat and roach preparations and also in inexpensive firecrackers known as "totes." Reports from Bogota, Colombia, indicate that acute yellow phosphorus poisoning reaches alarming proportions in that city, especially during the period surrounding the Christmas holidays.[5]

Phosphorus is a general protoplasmic poison and effects all organs of the body with its effects especially easily measured on the liver, kidney, brain and the heart. The factors which effect the clinical course are the amount ingested, the age of the patient, the time elapsed since ingestion, and subsequent management. The signs and symptoms of acute yellow phosphorus poisoning are classically divided in three stages.[2]

Three Stages

First Stage: This usually begins shortly after ingestion, but in some patients it may be delayed for several hours. Symptoms include nausea, vomiting, abdominal pain and shock. Diarrhea occurs only in about one-third of the patients.[2] During this stage the characteristic garlic odor may be detected or fumes may be seen from the vomitus or in the stool. In our patient, there was no history of pain and there was no shock at the time of admission. However, the presented patient vomited and refused to eat and the feces did contain the characteristic of fumes. The first

stage may last anywhere from 6 to 8 hours.[2]

Second Stage: If the patient does not succumb in the first stage, there ensues a symptom-free interval which usually lasts from 1 to 3 days, occasionally up to 10 days, during which the patient appears on the road to recovery. In our patient, the second stage was comparatively short and she rapidly progressed into the third stage within 24 hours of ingestion. The young age of our patient and the amount ingested could both explain the rapid onset of the third stage. The probability remains that the butter, which was administered to the child, greatly facilitated the absorption of the phosphorus and thus may have made the poisoning worse.[2]

Third Stage: During this stage, there is a systemic toxemia due to the action of the absorbed phosphorus. Hematemesis may occur due to the irritant effects on the gastrointestinal tract. The liver enlarges rapidly and nonspecific hepatic injury (nuclear vacuoles) can be seen in the liver cells as early as one hour after ingestion of phosphorus.[5] A hemorrhagic diathesis secondary to liver failure occurs. Renal involvement is manifest by hematuria, casts, and oliguria. The effects on the heart are manifest in the EKG by abnormalities in the ST segment and T waves. These are seen in both the limb and precordial leads.[8] Cerebral edema produces delirium, convulsions, and finally coma.

Pathological changes include esophagitis and fatty infiltration of the liver, kidney, stomach, intestines, and skeletal muscles. The liver is enlarged and has a lemon-yellow tint due to an extreme degree of fatty degeneration. Also, focal ischemic necrosis and acute inflammation of the portal areas may be seen. The central nervous system is especially vulnerable to phosphorus, becaue the phosphorus is lipophilic and therefore concentrated in the brain.[9]

Metabolic changes in phosphorus poisoning include early transient hyperglycemia followed by a profound hypoglycemia as the liver is destroyed. Urinary nitrogen may increase some 300 fold and involve all nitrogen containing compounds, but particularly toxic is ammonia. An increase in the BUN and in the blood amino acids is to be expected.

Before treating the patient with acute phosphorus poisoning, it is advisable for the examiner to put on a covering gown and gloves in order to prevent burning and absorption of phosphorus through the skin.[2] Gastric lavage with either cupric sulphate solution 1 gram to 1 pint of water or 1:1000 potassium permanganate solution should be done as both solutions form harmless oxidative products with phosphorus. Absorbable fats and oils tend to dissolve the phosphorus and to promote its absorption and the butter given to this child may well have increased the toxicity. However, 100-200 milliliters of liquid petrolatum (mineral oil) should be left in the stomach following lavage, as this is not absorbed and dissolves and holds the phosphorus.

The acute hepatic insufficiency is managed with intravenous dextrose, vitamin B complex, and vitamin K. Calcium gluconate is administered periodically to combat hypocalcemia. The acidosis, dehydration, and electrolyte imbalances are corrected with appropriate intravenous fluids. Should the patient go into shock, blood transfusions are indicated. Any local phosphorus burns are treated with 1% cupric sulfate solution.

Other supportive therapies have included exchange transfusion for the profound hepatic failure, but because of the rarity of the cases, there is no statistical proof that it is helpful. In many desperately ill children steroids are given; however, again there is no conclusive evidence that they will improve survival.[5]

Death may occur in any of these stages and may be due to irreversible shock, hepatic failure, central nervous system involvement, or massive hematemesis.[2] Recovery from stage three is most unusual. The mortality rate is approximately 50% according to Rubitzky-Myerson and Diaz Rivera et al.[2,6] The low mortality rate of 20% reported by Marin et al reflects the affects of an aggressive emergency treatment, as they anticipated the occurrence of the poisoning in their locality.[5]

Summary

Acute yellow phosphorus is an extremely toxic protoplasmic poison used to kill rats. Our recent fatal experience points out many of the problems associated with such toxicity. The patient is reported to warn physicians of the extraordinary toxicity of this type of rat poisoning which may be more widely seen now that the rats are becoming too resistant to warfrin derivatives. ◄

References

1. Bernardo, R. I.: "Acute Yellow Phosphorus Poisoning." *Amer. J. Med.*, 284:157, 1971.
2. Rubitsky, H. J. and Myerson, R. M.: "Acute Phosphorus Poisoning." *Arch. of Int. Med.*, 83:164-178, 1949.
3. Sollmann, T.: A Manual of Pharmacology and Its Application To Therapeutics and Toxicology. Edition Five. Philadelphia, W. B. Sanders Company. 1936.
4. McNally, W. D.: *Toxicology*. Chicago Industrial Medicine Publishing Company. 1937.
5. Marin, G. A., Montoya, C. A., Sierra, J. L., and Senior, J. R.: "Evaluation of Corticosteroid and Exchange Transfusion Treatment of Acute Yellow Phosphorus Intoxication." *Amer. Jl. of Med.*, 284:125-128, 1971.
6. Diaz-Rivera, R. S., Collazo, P. J., Pons, E. R., et al.: "Acute Phosphorus Poisoning in Main: A Study of 56 Cases." *Medicine* (Balt), 29:269-298, 1950.
7. Grollman, A. and Slaughter, D.: Cushing's Pharmacology and Therapeutics. Edition Thirteen. Philadelphia, Lea and Febiger. Page 188, 1947.
8. Katz, L. N.: Textbook of Electrocardiography. Philadelphia, Lea and Febiger. Page 253.
9. Wertham, F.: "Central Nervous System in Acute Phosphorus Poisoning." *Arch. of Neur. and Psych.*, 28:320, Aug. 1932.



medical legal review

The New Supplemental Security Income Program:

A Prospectus for the Medical Community

By Harry E. Grant, M.D.
Chief Medical Consultant, Federal Disability Program, Springfield

On January 1, 1974, a nationwide program of direct federal payments to aged, blind or disabled persons with limited income and resources went into effect. Known as "Supplemental Security Income" (SSI), the new program will have uniform eligibility requirements for such persons to replace the multiplicity of requirements existing under the present Federal-State public assistance programs.

The Supplemental Security Income program will be wholly financed from federal general tax revenues. Responsibility for administering the program has been given to the Social Security Administration (SSA), not only because of its experience in managing a monthly benefit payment program and the existing SSA advanced data processing system, but also because of the well-established nationwide network of SSA offices and program centers.

The title of the program, Supplemental Security Income, indicates that these benefits are expected in most cases to *supplement* income from other sources, including Social Security benefits. Those persons receiving public assistance on the basis of age (65), blindness, or disability according to State plans in effect for October, 1972, and who received such aid for December, 1973, will, in general, be converted to the Federal rolls beginning January, 1974.

Further, blind and disabled recipients will continue to be considered blind or disabled for SSI program purposes so long as they continue to meet the definition of blindness or disability under the State plan or the provisions for blindness or disability that apply to new claimants under the Federally administered program after December, 1973. According to preliminary data, it is estimated that about 6.2 million people including approximately 1.6 million blind and disabled people will be eligible in January, 1974, on this basis.

The federal law will pay many people who are not now eligible under state programs because they have income or resources above specified levels, or because their states have requirements making relatives responsible for their care. Also, many people who actually meet the state requirements do not apply for public assistance payments in states which have lien laws. Since the federal law has neither lien law nor relative-responsibility provisions, more people are expected to apply.

The states may, at their own option, elect to supplement the Federal SSI payment. Estimates are that about a million of the SSI recipients will receive additional state aid beyond the Federal payment.

The SSI program generally will use the same definitions of disability and blindness used in the Social Security Disability Insurance Program for determining eligibility in new claims. To help simplify and speed the processing of disa-

bility decisions and to insure uniform treatment of all applicants, no matter where they live, the medical evaluation criteria developed for the Title II Disability Insurance Program (Social Security) with the aid of practicing physicians, medical organizations and the Medical Advisory Committee to the Social Security Administration have been generally adopted for the SSI program. The evaluation criteria describe in terms of symptoms, signs and laboratory findings, impairments that reflect the level of severity that would prevent most people from working for a year or longer. These criteria are constantly being refined to reflect advances in medicine and to take into account disability program experience.

If an applicant has an impairment or a combination of impairments that meets or equals the criteria, and he is not working, he would generally be considered disabled. Most allowances are based on medical considerations alone; that is, the claimant's impairment meets or equals the level of medical severity in the criteria. It is also possible for an impairment to be slight or minimal, thereby resulting in a denial strictly on a medical basis. However, for workers who have impairments which fall short of the listed level of severity, but which prevent them from doing their previous or customary work, consideration is given to their ability to do any other work in light of their remaining capacity and of their age, education, training and work experience. In these cases, the individual must not only have an impairment which prevents him from doing his usual work, or work he has done previously, but also must be unable to do other kinds of work for which he is reasonably suited. In the situation where an older worker with a marginal education and a long history of arduous unskilled physical labor has an impairment which prevents him from doing his usual work, he may be considered under a disability.

All persons whose applications for determinations of disability are adjudicated in a State disability determination unit are referred to the State Vocational Rehabilitation Agency for consideration of rehabilitation services. The states will be fully reimbursed by the federal government through the Rehabilitation Services Administration for the services they provide to qualified disabled and blind SSI recipients.

With the anticipated doubling of the state disability determination unit workloads, emphasis will be placed on expanding resources with the medical community so that we will be able to get medical reports needed for adjudication of claims as quickly as possible. Although generally the same guides apply under Title II and Title XVI there are some differences. For example:

1. *No Waiting Period*—Under Title XVI (SSI), an individual who is determined to be blind or disabled will be eligible for payment for the first month in which he has filed an application and is disabled. There is no set waiting period which must be served after the onset of disability and during which payment cannot be made. (Under Title II, a five month waiting period must be served after the onset of disability.)

2. *Presumptive Disability*—The law provides that an applicant for disability benefits who is found to be "presumptively disabled" may be paid, under certain conditions, for as many as three months while a formal determination of his disability is being made. This provision, along with the absence of a waiting period under SSI, will intensify the need for obtaining medical evidence more rapidly so that disability determinations can be made promptly on claims filed by needy SSI applicants.

3. *Childhood Disability*—With the implementation of the SSI program, the Social Security Administration will for the first time be responsible for disability evaluation and payment for children who are under the age of 18. A child of a family with limited income and resources will be found disabled if the child has a medically determinable physical or mental impairment which can be expected to result in death; or which has lasted or can be expected to last for at least 12 consecutive months; and is of comparable severity to that which would prevent an adult from engaging in substantial gainful activity. The question of vocational assessment and concommitant ability to engage in substantial gainful activity is generally not relevant in evaluating disability during childhood because, in most situations, the child will not be of an age where he could reasonably be expected to enter the working population. Thus, in childhood cases, a finding of disability will be made solely on the basis of medical considerations including special medical criteria being developed for these cases within the above framework of consideration. There are, for example, severe impairments unique to childhood cases which are not now specifically described in the Social Security Listing of Impairments. The new medical criteria with appropriate signs, symptoms and laboratory findings are being formulated to eval-

(Continued on page 143)

Editorials



The Polar Controversy

Who was the first man to reach the North Pole? Officially, Rear Admiral Robert E. Peary U.S.N. has this distinction. He reached the North Pole on April 6, 1909. The renowned explorer was well provided with funds and manpower through the auspices of the wealthy Peary Artic Club. His technique was a traveling machine consisting of a series of pyramidal shuttles that required many men, sledges, and dogs. The entourage reached its peak and Peary then made a 132 mile dash to the pole.

Frederick A. Cook, M.D. claimed to have reached the pole one year sooner (April 21, 1908). He was a humble physician and lacked the funds available to Peary. No one believed him, but Cook made many careful observations along the way, many of which were refuted when Peary returned from the pole. Time is proving that Cook was telling the truth.

Dr. Cook got the same reception after he made the first ascent to reach the top of Mt. McKinley. According to Rear Admiral Charles W. Thomas, NSCG Ret., the Arctic Club latched on to the thesis ". . . false in one, false in all. . . ." But again, those who followed in Cook's footsteps found that his descriptions of what he saw were accurate.

Dr. Cook also got into legal difficulties during the Teapot Dome Scandal and was sent to jail. The government's charge against Dr. Cook was one of selling worthless oil stock. Harry M. Daugherty, Attorney General, was looking for a scapegoat and selected the humble "Polar Quack." While in prison, Cook's oilfield gushed forth and paid its investors $110 million. President Teddy Roosevelt recognized the gross injustice of the case and granted Dr. Cook a full pardon.

Physicians often get into trouble when they move out of the medical field. There is no doubt in my mind that Dr. Cook was honest, but he was up against a group of professionals who know how to push their convictions—integrity and human feelings be damned.

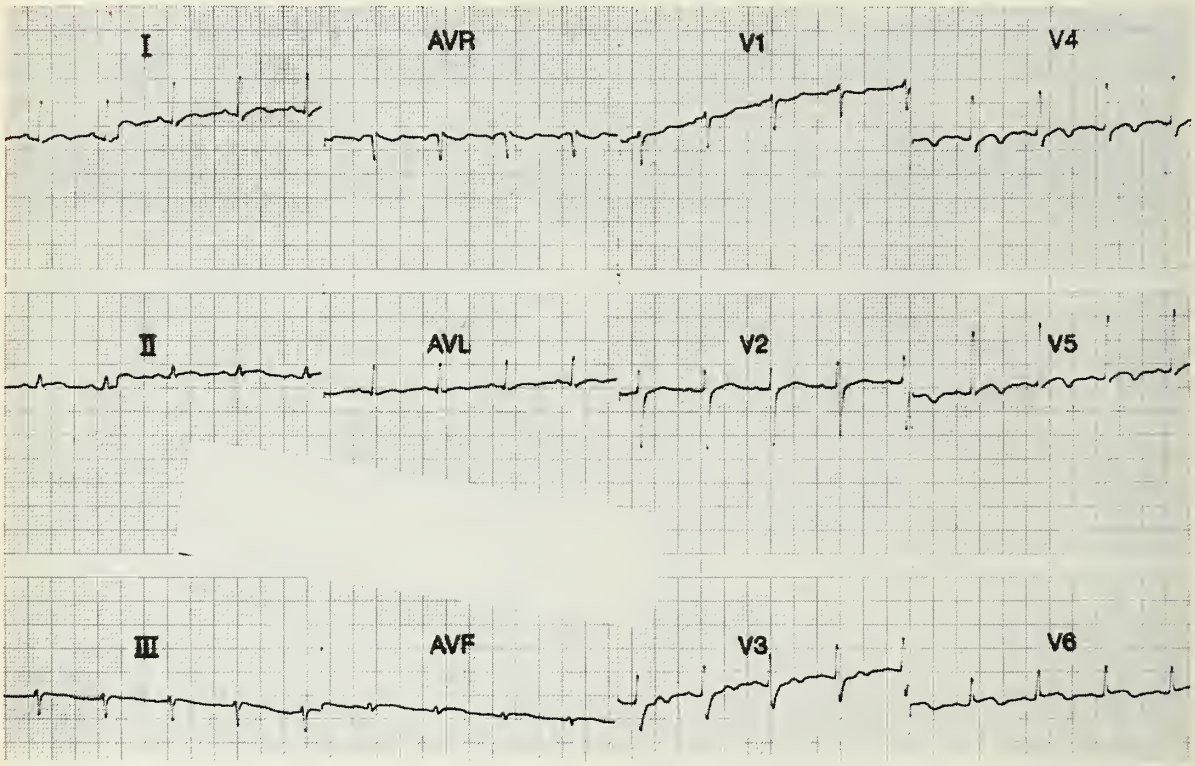
T. R. Van Dellen, M.D.
Editor

Important Skills

Humane scholarship is of utmost importance. Indeed, if we are not highly competent in dealing with patients, both directly, by talking to patients, examining them, and discussing with them their physical and personal problems, and indirectly, by transmitting to house staff, fellows, and nurses who accompany us on rounds, the sense of concern we feel for the patient, then we have missed the mark. These are fragile skills, as are our activities in the laboratory, and must be practiced to be preserved. There is, no doubt, an inherent tension between the drive toward academic productivity and the knowledge that caring for the patient and his well-being is of first priority. By vigorously investing energy into both activities, the true clinical investigator has learned to avoid entropy in both systems. Sound knowledge and self-assurance are partners in this venture; the humane scholar can, by imparting his knowledge and care for the patient to his team of house staff, nurses, and fellows, amplify his effectiveness, and achieve the tenuous goal, while remaining effective in other areas as well. (William B. Hood, Jr.: "The Stool As a Platform, Not A Seat." (Editorial) *Clinical Research* (Jan.) 1974, pp. 1-3.)

ekg of the month

John R. Tobin, M.D., M.S., Rimgaudas, Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., James V. Talano, M.D., Sarah Johnson, M.D. and Rolf M. Gunnar, M.D., M.S./Section of Cardiology, Loyola University Stritch School of Medicine



A 49-year-old housewife, was transferred from another hospital which she was admitted with a diagnosis of acute pancreatitis. She was hypotensive, thought to be hypovolemic, and had been treated with IV fluids and albumin with only slight improvement.

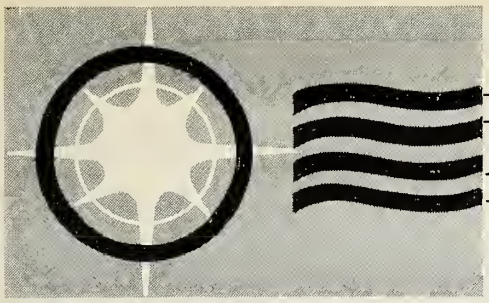
She gave a history of approximately a week prior to admission of experiencing some retrosternal discomfort which appeared to be aggravated by lying down and deep breathing. This disappeared within a day or two only to be replaced by epigastric and right upper quadrant pain, nausea and vomiting.

On examination she appeared to be an acutely ill white woman. Blood pressure was 100/70 in expiration and 80/60 on inspiration. Jugular venous pressure was estimated over 15 cm and did not decrease on inspiration. Chest was clear. The heart did not appear to be enlarged, it was quiet, S_1 was normal, S_2 was closely split, and there was a faint systolic rub along the left sternal border. The liver was enlarged and tender. There was no peripheral edema.

Questions:

1. **The admission electrocardiogram is suggestive of:**
 - A. Acute anterolateral wall myocardial infarction.
 - B. Early repolarization.
 - C. Acute pericarditis.
 - D. Hypocalcemia.
 - E. None of the above.
2. **The most likely clinical diagonsis is:**
 - A. Acute pancreatitis.
 - B. Acute pulmonary embolus.
 - C. Acute pericarditis with tamponade.
 - D. Congestive heart failure secondary to fluid overload.
 - E. None of the above.

(Answers on page 143)



membership forum

December 20, 1973

Dear Editor:

In commenting on Dr. Scrivner's 12 point Bill of Rights, the November issue of ILLINOIS MEDICAL JOURNAL states: ". . . the document is a declaration that physicians will resist increasing interference from government agencies, insurance companies and others outside the ranks of organized medicine."

From this statement, may I assume:

1. that ISMS opposes any and all constitutional amendments that would allow the government to interfere with the physician's right to perform abortions?
2. that IMPAC will actively lobby against any bill that would deny physicians the right to perform abortion according to their best medical judgement?
3. that ISMS and IMPAC will actively oppose any legislation that would deny Medicaid payments for abortion performed by licensed physicians according to their medical judgement?

Certainly the denial of payments for abortion and granting permission for the government (State or Federal) to prohibit physicians from performing abortions according to their best medical judgement, are both serious interferences with the right of physicians to make medical decisions.

Since abortion is not specifically excluded, may I conclude that the Bill of Rights does indeed include the right to perform abortions, and that ISMS and IMPAC will join ICMCA's effort in working against all the currently proposed legislation or any such future legislation designed to return abortion to criminal statutes, or lessen in any way, the right of the medical profession to make decisions regarding this medical procedure?

Sincerely,
Helen Smith, Executive Director
Lonny Myers, M.D., Advisory Committee
Illinois Citizens for the
Medical Control of Abortion

Dr. Scrivner responds

Dear Dr. Myers and Ms. Smith:

In your recent letter to the Editor of the ILLINOIS MEDICAL JOURNAL regarding my Physicians Bill of Rights you make three assumptions:

1. That ISMS opposes any and all constitutional amendments which would allow the government to interfere with the physician's right to perform abortions.
2. That IMPAC will actively lobby against any bill that would deny physicians the right to perform abortions according to their best medical judgment.
3. That ISMS and IMPAC will actively oppose any legislation that would deny Medicaid payments for abortions performed by licensed physicians according to their medical judgment.

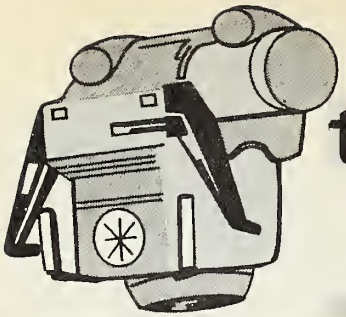
These matters relate to policies which are set by the ISMS House of Delegates and implemented by the Board of Trustees, or to IMPAC policy which is set by a council elected by members and implemented by the executive committee of that council.

Please understand that as an individual physician and member of ISMS I enjoy only those rights and privileges accorded to any other member, including accessibility to established mechanisms for making my opinions and beliefs known to our medical leadership. As President of ISMS and as one of 28 members of the Board of Trustees I have a small role in implementing policy.

I have offered my Bill of Rights as a guide to protect the rights of physicians and their patients, with the intent of safeguarding their traditional relationship. It is not intended to deal specifically with the many problems which arise in the daily practice of medicine.

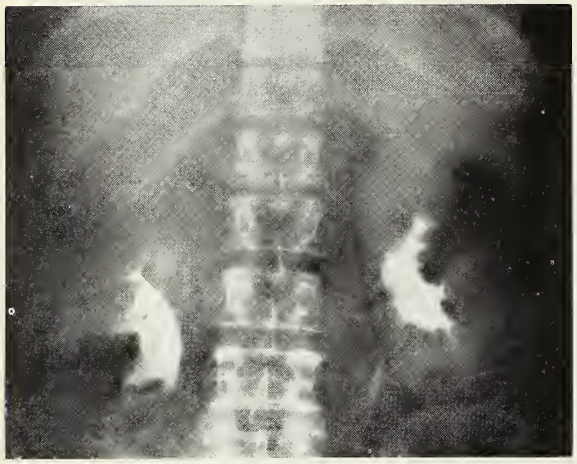
I suggest that you express your concern about the matters you have cited through the channels open to all members of ISMS—by requesting delegates who represent you in the ISMS House to introduce appropriate resolutions.

Sincerely,
Willard C. Scrivner, M.D.
ISMS President



the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



Patient is a 35-year-old female with a history of intermittent microscopic hematura.

What's your Diagnosis?

1. Transitional cell carcinoma and papilloma of renal pelvis
2. Aberrant papilla
3. Blood clots
4. Arterial impression

(Answer on page 146)



LOW-COST GROUP INSURANCE
ANOTHER ISMS MEMBERSHIP PRIVILEGE

THE GROUP DISABILITY PLAN ● Provides up to $300.00 weekly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

BUSINESS OVERHEAD EXPENSE PLAN ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

THE FAMILY MAJOR MEDICAL EXPENSE PLAN ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Gross Daily Hospital Room and Board available. ● Subject to choice of deductible and 80% coinsurance.

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

Central Illinois Service Office: 849 Forest Lane—Petersburg, Ill. 62675 • phone 217-632-7220
Wayne J. Hubbert, District Manager

Doctor's News

ISMS OPPOSES MEDICARE HOSPITAL ENTRY REGULATION—Under a new regulation proposed by the U.S. Department of Health, Education and Welfare, Medicare patients would have to be certified by a committee before their doctor could admit them to a hospital. According to ISMS President-Elect, Fredric Lake, the new regulations will be taken up by the ISMS Trustees at their next meeting. The society has long opposed interference with a relationship between a patient and his doctor.

MENTAL HEALTH CODE TO BE REVISED—A Governor's Commission, established by Executive Order of Governor Daniel Walker, will revise the Mental Health Code. The Commission will report on or before December 1, 1974. Judge Joseph Schneider of the Circuit Court of Cook County is Chairman of the Commission. Among the 32-members of the Commission are eight physicians, including Marshall Falk, M.D., and Ronald Schlensky, M.D., of the ISMS Council on Mental Health and Addiction. Judge Schneider has indicated that he would be most interested in the viewpoints and suggestions of the ISMS membership regarding how the Mental Health Code should be revised. Send comments to ISMS headquarters, c/o William Lees, M.D., for transmittal.

NEW REGULATIONS ON BLOOD DONORS—Two rule changes on who can donate blood have opened up a new field of potential donors. The permissible age has been lowered to 17 by the American Red Cross and American Association of Blood Banks (it previously was 18) and persons with a history of malaria can donate blood for use as plasma, three years after recovery from the disease. The change is based on the fact that malaria is transmitted only by cellular components of blood, such as red cells, and not plasma. Any 17-year-old donor still will require consent of his parents or guardian, unless the donor is married, self-supporting or in the armed forces. However, Illinois law still stipulates that donors be 18 or over. Until the law is changed the new ARC and AABB acceptance will not apply.

IDPH ISSUES DRUG WARNINGS—Recent warnings from IDPH have alerted the medical profession to the toxicity of products derived from apricot pits. These can be quite harmful and even fatal. Several of these products have been touted recently for use in Cancer chemotherapy. The FDA has banned these from interstate commerce and Illinois has banned them from intrastate commerce. Recently a Chicago physician was approached by a representative of a firm distributing a "Regimen for Early Cancer Therapy" which included Amygdalin Tablets, an apricot pit extract. This has been identified as a worthless drug. The physician, in addition, was invited to the home of the sales person to view a film to review the therapy regimen. Any physicians being so solicited are encouraged to gather the materials offered and send them to the Consumer Fraud Division of the Attorney General, 134 N. LaSalle St., Room 204, Chicago, 60602.

AMA-ERF ACCEPTING APPLICATIONS FOR LOANS—Applications from students of Illinois medical schools for loans under the interest-subsidized Medical Student Opportunity Loan Guarantee Plan are being accepted by the American Medical Association-Education and Research Foundations (AMA-ERF). Interested medical students should contact the AMA-ERF Program, c/o the AMA, 535 N. Dearborn St., Chicago, 60610.

SHARP INCREASE IN AMA MEMBERSHIP—More than 160,000 physicians have become dues-paid member of the American Medical Association, according to AMA. This is the sharpest increase in membership in a decade.

PHYSICIANS IN THE NEWS—**Dennis Lambert, M.D.**, has been appointed Director of Psychiatric Services for Children at Forest Hospital, Des Plaines. New officers elected to serve the Forest Hospital Medical Staff are: **Robert P. Cutter, M.D.**, President; **Karl L. Willrich, M.D.**, Vice President and **Roland de la Torre, M.D.**, Secretary-Treasurer.

Dean Bordeaux, M.D., Peoria, has been elected President of the Illinois Council on Continuing Medical Education. Other new officers are: **Edward W. Cannady, M.D.**, Belleville, Vice President; **Robert Fox, M.D.**, Glenview, Secretary and **Eli Borkon, M.D., Ph.D.**, Carbondale, Treasurer.

Frank W. Newell, M.D., has been named President-Elect of the American Academy of Ophthalomology and Otolaryngology.

SOUTHERN COOK COUNTY BRANCH MEDICAL SOCIETY HOLDING DINNER MEETING—The Southern Cook County Branch of the Chicago Medical Society will hold a dinner meeting, February 19, 1974, at Barthel's Supper Club, 833 E. 158th St., Dolton. Cocktails are at 6:30 and dinner at 7:30 p.m. Reservations must be made by calling Mrs. Conrad Urban, 335-1513.

Featured speaker for the dinner meeting will be Susan Jenkins, Program Officer, Bureau of Health Insurance, Social Security Administration of Kansas City. A discussion period on Medicare and Medicaid problems will be held.



S. Lloyd Teitelman, M.D.

New Medical Staff President at Michael Reese

S. Lloyd Teitelman, M.D., Chicago, has been elected President of the Medical Staff of Michael Reese Medical Center. Dr. Teitelman is senior attending physician, Department of Surgery at Michael Reese. A graduate of Northwestern University, Dr. Teitelman has taught at the University of Illinois and Chicago Medical School and is the author of numerous articles which have appeared in national publications. He is a member of the Illinois State Medical Society, Chicago Institute of Medicine, Alpha Omega Alpha and Fellow of the American College of Surgeons.

Dr. Hannas Elected to Top Position

R. R. Hannas, Jr., M.D., is the new president of the American College of Emergency Physicians. Dr. Hannas is the Director of Emergency Services for Evanston Hospital, Evanston, and is Associate in Surgery at Northwestern University Medical School. Dr. Hannas is a graduate of Harvard Medical School.



R. R. Hannas, Jr., M.D.

The New Supplemental Security Income Program

(Continued from page 132)

uate these cases. There also will be a need for frequent pediatric reports under the new program. The Illinois State Agency, therefore, has included in its 35 part-time physician staff, several pediatricians available for consultation to review reports on these types of cases.

4. *Drug Addiction and Alcoholism*—The law provides that a disabled person, who has also been medically determined to be a drug addict or alcoholic, shall be eligible for SSI payments only if he is undergoing treatment appropriate for his condition as an addict or alcoholic at an approved institution or facility, if one is available. An eligible individual who has been medically determined to be a drug addict or alcoholic must receive benefits via a representative payee.

5. *Blindness*—The criteria for establishing blindness under SSI are identical to those required to establish statutory blindness under the Social Security Disability Insurance Program. Unlike Title II, however, engagement in substantial gainful activity will not preclude SSI payments if the statutory definition of blindness is met, although the SSI payments may be reduced under the income test. Also, since there is no duration requirement for blindness under SSI, there can be a favorable decision based on temporary blindness. Once again, the need for comprehensive and prompt medical reports must be underscored.

Implementation of the SSI program will undoubtedly give rise to new questions and point out areas of concern with respect to the medical community and the State Agencies. If you have any further questions or desire additional information, contact: Harry E. Grant, M.D., Box 3842, Springfield, 62708, or phone (217) 525-1520. ◄

EKG of the Month

(Continued from page 134)

Answers: *1. C 2. C.*

Tracing shows generalized ST elevation without reciprocal changes suggestive of acute pericarditis. The clinical findings point towards diagnosis of acute pericarditis with tamponade. An emergency pericardiocentesis was performed with ECG monitored exploring needle. 150 cc of serosanguinous fluid was removed. Serum amylase was negative. Fluid reaccumulated and the next day the patient was taken to the operating room where anterior pericardiectomy was performed. Diagnosis was idiopathic pericarditis. ◄



Is Yours for the asking

No Collateral!
No Endorsers!
No References!

This is a completely confidential source of unsecured credit for professional people wishing to borrow at least $2,000.00 for 12 to 36 months. No endorsers are needed! No references are checked! No information other than the original application is ever required! And, all transactions are conducted in complete privacy by unmarked mail.

To borrow up to $7,500.00 in absolute confidence, you must have annual income of at least $20,000.00 and be between 30 and 65 years of age. If you qualify—call C. W. Conner, Professional Loan Director, at this Toll Free number for a loan application: 800/238-7545 (Tennessee residents call collect 901/523-1461).

Your application can be processed and a check mailed in only two weeks. It's yours for the asking. Larger amounts are available upon request.

Murdock
Acceptance Corporation
P. O. Box 158 • Memphis, Tenn. 38101
Phone 901/523-1461

TAX-FREE MUNICIPAL BONDS

Safety Marketability

M. B. VICK & COMPANY
Established 1933
120 South La Salle Street
Chicago, Ill. 60603
312-346-3344

Satisfying the needs of individual investors for over 40 years.

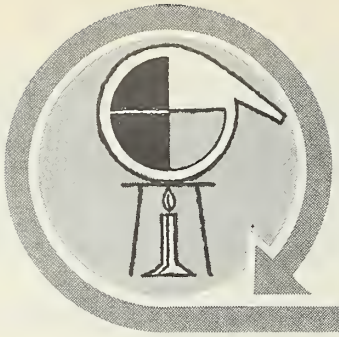
Call or write one of our Municipal Bond specialists

Name.....

Address.....

City.....

Zip..... State.....



new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

PROSTIN F_2 alpha Oxytocic ℞

Manufacturer: The Upjohn Company
Nonproprietary Name: Dinoprost Tromethamine
Indications: Termination of second trimester pregnancy.
Contraindications: Hypersensitivity to the drug. Acute pelvic inflammatory disease.
Warnings and Precautions: See package insert.
Dosage: Intra-amniotic administration as described in package insert.
Supplied: Ampules, 4 and 8 cc.
Distribution: Limited to university hospital centers.

TOFRANIL-PM Psychostimulant ℞

Manufacturer: Geigy Pharmaceuticals
Nonproprietary Name: Imipramine Pamoate
Indications: Symptoms of endogenous depression
Contraindication: Use of monoamine oxidase inhibitors, hyperpyrectic crises or severe convulsive disorders.
Warnings: See package insert.
Dosage: Initiate dose at low level and increase gradually. Use lower dose in adolescents and elderly patients. Once a day maintenance dose 75 to 150 mg. at bedtime.
Supplied: Capsules, 75 and 150 mg.

DUPLICATE SINGLE DRUGS

KEFZOL Broad Spectrum Antibiotic ℞

Manufacturer: Eli Lilly and Co.
Nonproprietary Name: Cefazolin Sodium
Indications: Infections due to susceptible organisms of the respiratory and genitourinary tract, skin, soft tissue, bone and joint, septicemia and endocarditis.
Contraindications: Patients with known allergies to penicillin.
Warnings: Use with caution in patients allergic to penicillin.
Dosage: Follow instructions of package insert.
Supplied: Vials, 250, 500 and 1,000 mg. of base

NEW DOSAGE FORMS

CLEOCIN PEDIATRIC Broad Spectrum Antibiotic ℞

Manufacturer: The Upjohn Company
Nonproprietary Name: Clindamycin Palmitate HCl
Indications: Treatment of upper and lower respiratory tract infections, including Group A streptococcal pharyngitis and tonsilitis, rheumatic fever and other susceptible organisms.
Contraindications: Known hypersensitivity to preparations contain clindamycin or lincomycin.
Dosage: See package insert.
Supplied: Dry Pint packets—each reconstitutes to 30 cc. suspension.

GENERIC DRUG

BISACODYL Laxative o.t.c.

Manufacturer: Philips Roxane
Nonproprietary Name: Bisacodyl
Indications: Constipation
Dosage: Two or three tablets, taken at bedtime or before breakfast, children over 6 one tablet.
Supplied: Tablets 5 mg. ◄

▲ **Milwaukee Psychiatric Hospital** { Intensive, dynamic psychotherapy for adults and adolescents, individually planned activity therapy.

▲ **Milwaukee Sanitarium** { Geriatric program of superior care . . . custodial services for persons with chronic emotional illness.

▲ **Dewey Center** { Acute detoxification and inpatient treatment for alcoholic dependency, daily schedules, broad supportive services.

Units of: MILWAUKEE SANITARIUM FOUNDATION
1220 DEWEY AVENUE • WAUWATOSA, WIS. 53213 • PHONE (414) 258-2600

Affiliated with Medical College of Wisconsin

Accredited by the Joint Commission on Accreditation of Hospitals

Non-Profit Non-Sectarian Est. 1884 Participating Member Blue Cross-Blue Shield

ABBOTT

acidyl®
(CHLORVYNOL)

ief Summary

ations—Placidyl (ethchlorvynol) is indicated hort-term hypnotic therapy in the management somnia.

raindications—Drug hypersensitivity and por-a.

ings—Not recommended during the first and nd trimester of pregnancy. Caution patients ossible combined exaggerated effects with ol, barbiturates, tranquilizers or other CNS essants. Exaggerated effects might result in ng of vision, paralysis of accommodation and und hypnosis. Caution patients concerning g a motor vehicle, operating machinery, or hazardous operations requiring alertness af-king the drug. ADMINISTER WITH CAUTION ATIENTS WITH SUICIDAL TENDENCIES AND IOT PRESCRIBE LARGE QUANTITIES OF THE . Adjustment of the dosage of oral anticoag-s might be necessary when beginning ethchlor-therapy, during therapy, or after stopping py. This drug is not recommended for use in ren. PLACIDYL HAS THE POTENTIAL FOR DEVELOPMENT OF PSYCHOLOGICAL AND ICAL DEPENDENCE. INSTANCES OF SE-WITHDRAWAL SYMPTOMS, INCLUDING VULSIONS AND DELIRIUM CLINICALLY SIM-TO THOSE SEEN WITH BARBITURATES, BEEN REPORTED IN PATIENTS TAKING ULAR DOSES AS LOW AS 1000 MG. PER DAY A PERIOD OF TIME WHEN THE DRUG WAS DENLY DISCONTINUED. PROLONGED AD-STRATION OF THE DRUG IS NOT RECOM-DED. Addiction-prone patients or those who kely to increase dosages of the drug on their initiative should be observed for evidence of or symptoms which may indicate possible withdrawal or abstinence symptoms. Signs symptoms associated with withdrawal and ab-nce include unusual anxiety, tremor, ataxia, ng of speech, memory loss, perceptual dis-ns, irritability, agitation and delirium. Other well defined signs and symptoms, not neces-due to withdrawal and abstinence, may in-anorexia, nausea or vomiting, weakness, ess, sweating, muscle twitching and weight Abrupt discontinuance of Placidyl following nged overdosage may result in convulsions elirium.

utions—Toxic amblyopia has been reported long-term continuous use of ethchlorvynol. anent visual defects have been observed, al-h amblyopia has improved after discontinua-of the drug. Drug dosage should be limited derly and debilitated patients to the smallest ive amount. If pain is present, this drug d only be given if insomnia persists after is controlled with analgesics. Caution is ad-in prescribing the drug for patients who are treated with either MAO inhibitors or anti-essants. Transient delirium has been reported the combination of Placidyl and amitryptyline. dosage should be reduced if prescribed for nts receiving MAO inhibitors or antidepres-. Caution should be exercised in patients impaired hepatic or renal function. Patients respond unpredictably to barbiturates or alco-or who exhibit excitement and release of inhi-in association with such agents, may also in this way to Placidyl. Rarely, patients may it symptoms suggestive of an unusual sus-bility to the drug, such as prolonged hypnosis, und muscular weakness, excitement, hysteria, ncope without marked hypotension. Transient ness or ataxia may occur.

rse Reactions—Hypotension, nausea or vom-gastric upset, aftertaste, blurring of vision, ess, facial numbness, and allergic reaction ed by urticaria have been reported following dyl administration. Mild "hangover" and symp-of mild excitation have occurred in some nts. There have been rare reports of cholestatic lice occurring in patients taking ethchlorvynol. w cases of thrombocytopenia have been re-d in patients receiving ethchlorvynol. 305432



Give us her nights.

Prescribe Placidyl. Chances are, we'll give her a good night's sleep.

Insomnia is often suffered by the elderly. Anxiety and agitation might be the cause. Or the effect. In time that can be determined. But tonight one fact is painfully clear: she needs sleep.

When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

If time is the criterion to inspire your confidence . . . you can rest assured with Placidyl.

Prescribed by physicians for over 17 years.

Placidyl® CIV

(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)

View Box

(Continued from page 136)

Diagnosis: *Aberrant Papilla*—An aberrant papilla is an otherwise normal renal papilla which projects directly into the lumen of the infundibulum without benefit of the normal, flared minor calyx. Aberrant papillae may arise as a result of asymmetric branching of the bud, whereby one tubule may develop normally and another form without a normal calyx. The result is an abnormally situated papilla which may appear as an intraluminal mass.

The aberrant papilla in typical form is a smooth, conical shaped mass that appears round or oval when seen on end. Its attachment to one wall is broad and can usually be demonstrated by roentgenograms obtained in various degrees of obliquity. Unlike intrarenal tumors and cysts, the collecting structures are not distorted or obstructed.

Also, unlike exstrinsic impressions from vessels, aberrant papillae produce constant defects that do not become obliterated by distention of the collecting structures. It is believed that aberrant papillae represent one end of a spectrum of minor anomalies of calyceal development. In some instances a minor calyx is shortened. This shortening may produce a filling defect surrounded by a radiopaque ring; oblique views, however, usually reveal their true nature. In other cases, multiple papillae enter a single calyx and may be confused with other causes of filling defects. In this patient's case the symptoms cleared and nothing further was done. ◄

Thymoma Erythroid Hypoplasia and Myasthenia Gravis

(Continued from page 124)

The presence of desmosomes does not appear to represent evidence of differentiation of the tumor. We have observed a cytologically malignant thymoma, with rare poorly developed desmosomes and one of Toker's cases, although benign had similar features. Our present case showed a uniform picture of numerous large and well developed desmosomes.

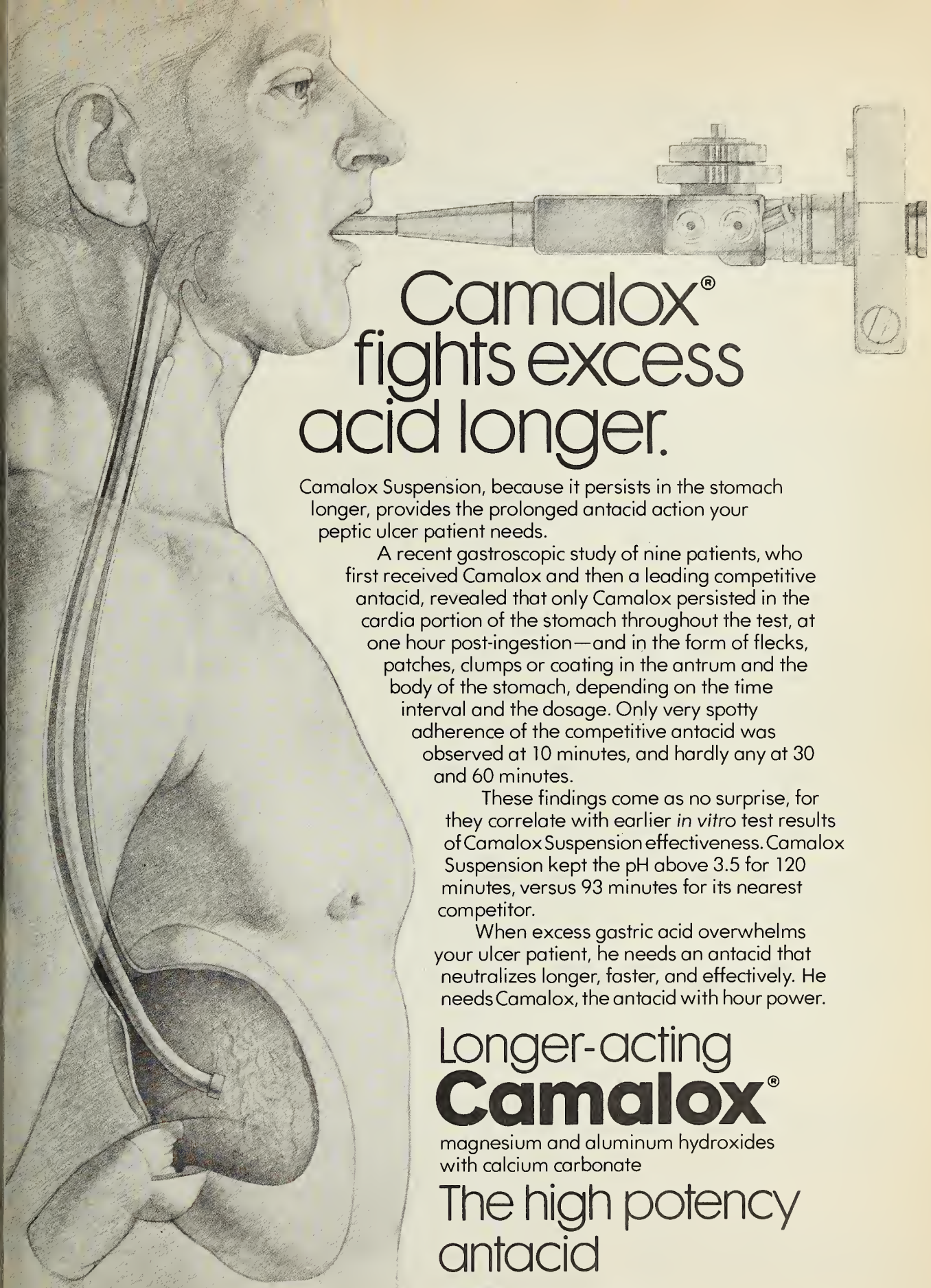
Further studies of these interesting neoplasms are in order to elucidate the relationship of the cellular organelles to the degree of maturation as a possible indicator of the eventual behavior of the tumor. ◄

References

A complete bibliography for "Thymoma, Erythroid Hypoplasia and Myasthenia Gravis—Report of a Case with Ultrastructual Study," may be obtained by writing to the *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago, 60601.

75 YEARS
Professional Protection
CONTINUOUSLY
Since 1899
THE MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

CHICAGO AREA OFFICE:
T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives
815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251



Camalox® fights excess acid longer.

Camalox Suspension, because it persists in the stomach longer, provides the prolonged antacid action your peptic ulcer patient needs.

A recent gastroscopic study of nine patients, who first received Camalox and then a leading competitive antacid, revealed that only Camalox persisted in the cardia portion of the stomach throughout the test, at one hour post-ingestion—and in the form of flecks, patches, clumps or coating in the antrum and the body of the stomach, depending on the time interval and the dosage. Only very spotty adherence of the competitive antacid was observed at 10 minutes, and hardly any at 30 and 60 minutes.

These findings come as no surprise, for they correlate with earlier *in vitro* test results of Camalox Suspension effectiveness. Camalox Suspension kept the pH above 3.5 for 120 minutes, versus 93 minutes for its nearest competitor.

When excess gastric acid overwhelms your ulcer patient, he needs an antacid that neutralizes longer, faster, and effectively. He needs Camalox, the antacid with hour power.

Longer-acting **Camalox®**

magnesium and aluminum hydroxides with calcium carbonate

The high potency antacid

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
360 No. Michigan Ave. • Chicago, IL 60601 • (312) 782-1654

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

MARCH

Anesthesiology

WORKSHOP

For: Anesthesiologists. 2-day workshop, March 2-3, 1974, Marriott Motor Hotel, St. Louis, Mo.

Hrs. of Instr.: 16. **CME Credit:** AMA Category 1. **Fee:** $75 (members), $100 (non-members). **Reg. Limit:** 250.

Sponsor, contact: American Soc. of Anesthesiology, 515 Busse Hwy., Park Ridge, IL 60068.

ELECTROCARDIOGRAPHY FOR ANESTHESIOLOGISTS

For: All physicians. March 4-8, 1974, Chicago, Ill.

Hrs. of Instr.: 35. **CME Credit:** AMA Category 1. **Fee:** $150 (approx.). **Reg. Limit:** 35.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Cancer

DIAGNOSIS & MANAGEMENT OF MAMMARY CANCER

For: All physicians. Frontiers of Medicine lecture, March 13, 1974, 2 p.m., Billings Hospital, Chicago.

Hrs. of Instr.: 3. **CME Credit:** AAFP, AMA Category 1. **Fee:** $15.

Sponsor, contact: Frontiers of Medicine, Univ. of Chicago, Box 451, 950 E. 59th St., Chicago, IL 60637.

Cardiovascular Disease

PATHOLOGY OF THE HEART

For: All physicians. 2½-day conference, March 21-23, 1974, Palmer House, Chicago, Ill.

Hrs. of Instr.: 20. **CME Credit:** AMA Category 1. **Fee:** $100 (members), $150 (non-members).

Sponsor, contact: Amer. College of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014.

VASCULAR SURGERY FOR THE PRACTICING PHYSICIAN

2-day conference, March 23-24, 1974, Marc Plaza Hotel, Milwaukee, Wis.

Sponsor, contact: Medical College of Wis., 561 N. 15th St., Milwaukee, Wis. 53233.

CARDIOLOGY TODAY—RECENT ADVANCES IN CARDIOLOGIC TREATMENT & DIAGNOSIS

For: All physicians. 4-day course, March 25-28, 1974, Univ. of Iowa College of Med., Iowa City, Ia.

Hrs. of Instr.: 40. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 12.

Sponsor, contact: Univ. of Iowa Coll. of Med., Newton Rd., Iowa City, Ia. 52242.

Dermatology

ONE WEEK COURSE IN BASIC DERMATOLOGY

For: Family physicians. March 25-29, 1974, Chicago.

Hrs. of Instr.: 30. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 30.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Electrocardiography

BASIC ELECTROCARDIOGRAPHY

For: Family physicians. March 4-8, 1974, Chicago.

Hrs. of Instr.: 35. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 35.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

ELECTROCARDIOGRAPHIC INTERPRETATION OF ARRHYTHMIAS: A PHYSIOLOGICAL APPROACH

For: Cardiologists. March 25-27, 1974, Indiana Univ. Med. Center, Indianapolis, Ind.

Hrs. Instr.: 24. **CME Credit:** AMA Category 1. **Fee:** $100 (mem.), $150 (non-mem.). **Reg. Limit:** 60.

Sponsor, contact: American Coll. of Cardiology, 9650 Rockville Pike, Bethesda, Md. 20014.

Emergency Care

HOSPITAL PROGRAM ON GENERAL SURGERY/TRAUMA

For: All physicians. Monthly clinical program, March 12, 1974, 8 p.m., Loyola Univ. Med. Cntr., Maywood.

Hrs. of Instr.: 2. **Fee:** none.

Sponsor: Chicago Committee on Trauma, American College of Surgeons. **Contact:** Arne E. Schairer, M.D., 30 N. Michigan Ave., Chicago, IL 60602.

HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA

For: All physicians. Monthly clinical program, March 19, 1974, 8 p.m., Illinois Masonic Hospital, Chicago,

Hrs. of Instr.: 2. **Fee:** none.

Sponsor: Chicago Committee on Trauma, American College of Surgeons. **Contact:** Howard W. Schneider, M.D., 238 W. 154th St., Harvey, IL 60426.

Internal Medicine

IMMUNOLOGY OF INFECTIONS

For: Pediatricians, Internists, Family Physicians. Symposium, March 6, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, 46202.

OBESITY

For: All physicians. Seminar, lecture, March 15, 1974, 10 a.m., Bethany Methodist Hospital; March 15, 6 p.m., Lincolnwood Hyatt House; March 16, 10 a.m., Belmont Community Hospital.

Hrs. of Instr.: 5. **CME Credit:** AAFP, AMA Category 1. **Fee:** $10 (non-staff, for dinner). **Reg. Deadline:** March 11, 1974.

Sponsor: FAB3-CME. **Contact:** Mr. D. Larson, Bethany Methodist Hospital, 5025 N. Paulina St., Chicago, IL 60640; (312)271-9040.

BASIC INTERNAL MEDICINE

For: Family physicians. March 18-22, 1974, Chicago.

Hrs. of Instr.: 40. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 50.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

INTERNAL MEDICINE REVIEW

For: Internists, Pediatricians, Family Phys. Symposium, March 20-21, 1974, Atkinson Hotel, Indianapolis.

Hrs. of Instr.: 12. **CME Credit:** AAFP, AMA Category 1. **Fee:** $50.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, 46202.

CHRONIC RESPIRATORY DISEASE PROGRAM

For: All physicians. 5-day conference, March 25-29, 1974, Indianapolis, Ind.

Hrs. of Instr.: 30. **CME Credit:** AMA Category 1.

Sponsor, contact: Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

Neurology

BASIC NEUROLOGY, PART I

For: All physicians. March 25-30, 1974, Chicago.

Hrs. of Instr.: 44. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 80.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

CLINICAL NEURO-OPHTHALMOLOGY

For: Neurologists & Ophthalmologists. Symposium. March 27, 1974, Methodist Hospital, Indianapolis, Ind.

Hrs. of Instr.: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, 46202.

Obstetrics/Gynecology

ONE WEEK COURSE IN BASIC OBSTETRICS

For: Family physicians. March 25-29, 1974, Chicago.

Hrs. of Instr.: 35. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 20.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Otolaryngology

LARYNGOLOGY & BRONCHOESOPHAGOLOGY

For: Otolaryngologists, Thoracic Surgeons. March 18-23, Univ. of Ill. Eye & Ear Infirmary, Chicago.

Hrs. of Instr.: 45. **Fee:** $300. **Reg. Limit:** 15.

Sponsor, contact: Dept. of Otolaryngology, Univ. of Ill. Coll. Med., 1855 W. Taylor St., Chicago, 60612.

HEAD & NECK ANATOMY & CLINICAL OTOLARYNGOLOGY

For: Otolaryngologists. Symposium, March 18-29, 1974, Indianapolis, Ind.

Hrs. of Instr.: 112. **CME Credit:** AAFP, AMA Category 1. **Fee:** $650. **Reg. Limit:** 27.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, 46202.

Pediatrics

CHRONIC ILLNESS IN CHILDHOOD

For: Pediatricians. Half-day roundtable, March 20, 1974, Loyola University Medical Center, Maywood, Ill.

Hrs. of Instr.: 4. **Fee:** $10. **Reg. Deadline:** March 18

Sponsor: Dept. of Pediatrics, Loyola Univ. Stritch Sch. of Med. **Contact:** Pediatrics Roundtables, c/o Eugene F. Diamond, M.D., 2160 S. 1st Ave., Maywood, IL 60153.

Radiology

LECTURE

For: Radiologists & Residents in Radiology. Lecture, March 21, 1974, Bismarck Hotel, Chicago, Ill.

Sponsor: Illinois Radiological Society. **Contact:** Raymond L. Del Fava, M.D., Secy., Chgo. Rad. Soc., St. Francis Hospital, 3355 Ridge Ave., Evanston, 60202.

Surgery

MANAGEMENT OF COMPLICATIONS IN SURGERY

For: All physicians. March 11-14, 1974, Chicago, Ill.

Hrs. of Instr.: 28. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 55.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

MARCH, cont.

PRE & POST OPERATIVE CARE OF PATIENTS FOR SURGEONS & SURGICAL SPECIALISTS

4-day course, March 12-15, 1974, Chicago, Ill.

Hrs. of Instr.: 31½. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 80.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

SURGERY REVIEW

For: Surgeons. Symposium, March 14-15, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, 46202.

BLOOD VESSEL SURGERY

For: Specialists. March 25-29, 1974, Chicago.

Hrs. of Instr.: 40. **CME Credit:** AMA Category 1. **Fee:** $250. **Reg. Limit:** 40.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

APRIL

Anesthesiology

COURSE I—CLINICAL ANESTHESIA PRACTICE

22-day course, April 1-30, 1974, Chicago, Ill.

Hrs. of Instr.: 176. **CME Credit:** AMA Category 1. **Fee:** $400.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Cardiovascular Disease

ADVANCED CARDIOLOGY

For: Cardiologists. April 15-19, 1974, Chicago.

Hrs. of Instr.: 30. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 35.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

HEMATOLOGICAL DISEASES

For: All physicians. Seminar, lecture, April 19, 1974, 10 a.m., Belmont Community Hospital; April 19, 6 p.m., Lincolnwood Hyatt House; April 19, 10 a.m., American Hospital, Chicago.

Hrs. of Instr.: 5. **CME Credit:** AAFP, AMA Category 1. **Fee:** $10 (non-staff, for dinner). **Reg. Deadline:** April 15, 1974.

Sponsor: FAB^3-CME. **Contact:** Mr. J. McCracken, Belmont Community Hosp., 4058 W. Melrose St., Chicago, IL 60641; (312) 736-7000.

HYPERTENSION—THE SILENT DISEASE

For: All physicians. April 25-26, 1974, Holiday Inn East, Springfield, Ill.

Hrs. of Instr.: 9. **CME Credit:** AMA Category 1. **Fee:** $20.

Sponsor, contact: Ill. Heart Assn., 1181 N. 31st St., P.O. Box 2666, Springfield, IL 62708.

Emergency Care

HOSPITAL PROGRAM ON MUSCULO-SKELETAL & GENERAL SURGERY TRAUMA

For: All physicians. Monthly clinical program, April 4, 1974, 8 p.m., Mercy Hospital, Chicago, Ill.

Hrs. of Instr.: 2.

Sponsor: Chicago Committee on Trauma, American College of Surgeons. **Contact:** Arne E. Schairer, M.D., 30 N. Michigan Ave., Chicago, IL 60602.

Family Medicine

FAMILY PRACTICE REVIEW

For: Family physicians. April 8-12, 1974, Chicago.

Hrs. of Instr.: 40. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 50.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

PUTTING THE "FAMILY" INTO FAMILY PRACTICE

For: Family physicians, Family therapists. 2-day seminar, April 19-20, 1974, Oak Brook Hyatt House, Oak Brook, Ill.

Hrs. of Instr.: 12. **CME Credit:** AAFP. **Fee:** $60.

Sponsor: Family Practice Cntr., MacNeal Mem. Hospital; **Contact:** H. R. Hone, M.D., MacNeal Mem. Hosp., 3249 S. Oak Park Ave., Berwyn, IL 60402.

General

MIDWEST CLINICAL CONFERENCE

For: All physicians. April 3-7, 1974, Conrad Hilton Hotel, Chicago, Ill.

Instructional Courses Offered: April 3, Cardiovascular Emergency, Psychiatric Problems in Everyday Practice; April 4, Recent Advances in Cancer Immunotherapy & Chemotherapy, Obstetrics & Gynecology; April 5, Hypertension, Emergency Room Medicine.

For above courses: Fee: $25/course. **CME Credit:** AAFP, AMA Category 1. **Registration in advance.**

In addition, many specialty societies will hold scientific sessions.

Sponsor, contact: Chicago Med. Soc., 310 S. Michigan Ave., Chicago, IL 60604.

"HOW TO IDENTIFY NEEDS IN CONTINUING MEDICAL EDUCATON"—2nd ANNUAL ILLINOIS CONGRESS ON CME

For: All interested in CME. Conference/workshop, April 18, 1974, Oak Brook Hyatt House, Oak Brook.

Hrs. of Instr.: 7. **CME Credit:** AMA Category 1. **Fee:** $25. **Reg. Limit:** 100.

Sponsor, contact: Ill. Council on CME, 360 N. Michigan Ave., Chicago, IL 60601.

Internal Medicine

ADVANCES IN MEDICINE

For: Internists. April 8-12, 1974, Chicago.

Hrs. of Instr.: 35. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 50.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Neurology

REVIEW COURSE IN NEUROPATHOLOGY

For: Specialists. April 1-6, 1974, Chicago.

Hrs. of Instr.: 40. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 30.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Obstetrics/Gynecology

ONE WEEK COURSE IN BASIC GYNECOLOGY

For: Family physicians. April 1-5, 1974, Chicago, Ill.

Hrs. of Instr.: 35. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 20.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

RECENT ADVANCES IN OBSTETRICS & GYNECOLOGY

For: Internists & Osteopaths. Symposium, April 22-23, 1974, Clopton Auditorium, Washington Univ. School of Medicine, St. Louis, Mo.

Hrs. of Instr.: 13. **CME Credit:** AAFP. **Fee:** $50 ($10 House Officers). **Reg. Limit, Deadline:** 200, April 15.

Sponsor, contact: Washington Univ. Sch. of Med., Office of CME, 660 S. Euclid Ave., St. Louis, Mo. 63110.

CURRENT DEVELOPMENTS IN CARE OF HIGH RISK OBSTETRICAL PATIENT & NEWBORN

2-day conference, April 23-24, 1974, Univ. of Iowa Mem. Union, Iowa City, Iowa.

Hrs. Instr.: 12. **CME Credit:** AMA Category 1. **Fee:** $10.

Sponsor, contact: Univ. of Iowa College of Med., Newton Rd., Iowa City, IA 52242.

Orthopedics

OFFICE ORTHOPAEDICS

For: Family physicians, Pediatricians. Symposium, April 17, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35.

Sponsor, contract: Mr. John Roscoe, Indiana Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, 46202.

LOW BACK: INJURY & DISEASE

For: All physicians. 3-day conference, April 25-27, 1974, Sheraton-Chicago Hotel, Chicago, Ill.

CME Credit: AMA Category 1. **Fee:** $150 (M.D.s); $50 (Residents). **Reg. Limit:** 350.

Sponsor, contact: Amer. Acad. of Orthopaedic Surgeons, 430 N. Michigan Ave., Chicago, IL 60611.

Pediatrics

CURRENT PEDIATRIC MANAGEMENT—A NEW & INDIVIDUALIZED TEACHING COURSE

For: Family physicians, Pediatricians. Symposium, April 3, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, 46202.

ADVANCES IN NEONATOLOGY

For: Specialists. April 22-23, 1974, Chicago, Ill.

Hrs. of Instr.: 14. **CME Credit:** AMA Category 1. **Fee:** $60. **Reg. Limit:** 100.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Psychiatry

PSYCHIATRY & DRUG ABUSE

For: All physicians. Frontiers of Medicine lecture, April 10, 1974, 2 p.m., Billings Hospital, Chicago.

Hrs. of Instr.: 3. **CME Credit:** AAFP, AMA Category 1. **Fee:** $15.

Sponsor, contact: Frontiers of Medicine, Univ. Chgo., Box 451, 950 E. 59th St., Chicago, 60637.

Radiology

WORKSHOP IN DIAGNOSTIC RADIOLOGY

For: Physicians, Residents, & Technologists. 5-day workshop, April 1-5, 1974, Northwestern Univ. Med. Sch., Chicago, Ill.

Sponsor, contact: Div. of Radiological Physics, Northwestern Mem. Hospital—Wesley Pavilion, 250 E. Superior St., Chicago, IL 60611.

DOSIMETRY

For: Physicians, Residents, & Technologists. 5-day workshop, April 15-19, 1974, Northwestern Univ. Med. Sch., Chicago, Ill.

Sponsor, contact: Div. of Radiological Physics, Northwestern Mem. Hospital—Wesley Pavilion, 250 E. Superior St., Chicago, IL 60611.

DIAGNOSTIC RADIOLOGY

For: Family physicians. April 16-20, 1974, Chicago.

Hrs. of Instr.: 35. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 25.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

LECTURE

For: Radiologists & Residents in Radiology. April 18, 1974, Bismarck Hotel, Chicago, Ill.

Sponsor: Illinois Radiological Soc. **Contact:** Raymond L. Del Fava, Secy., Chicago Rad. Soc., St. Francis Hosp., 3355 Ridge Ave., Evanston, IL 60202.

RADIOLOGY

For: Radiologists. Symposium, April 24-26, 1974, Marion County Gen. Hosp., Indianapolis, Ind.

Hrs. of Instr.: 21. **CME Credit:** AAFP, AMA Category 1. **Fee:** $115.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. Med., 1100 W. Michigan Ave., Indianapolis, 46202.

Surgery

SURGERY OF THE GASTROINTESTINAL TRACT

For: Specialists. April 8-12, 1974, Chicago.

Hrs. of Instr.: 40. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 55.

Sponsor, contact: Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

ANNUAL MEETING

For: Members & Applicants to American College of Surgeons. April 19-20, 1974, Springfield, Ill.

Sponsor: Illinois Chapter, Amer. Coll. Surgeons, **Contact:** Otto Metzmaker, M.D., 614 E. Carpenter St., Springfield, Ill.

Urology

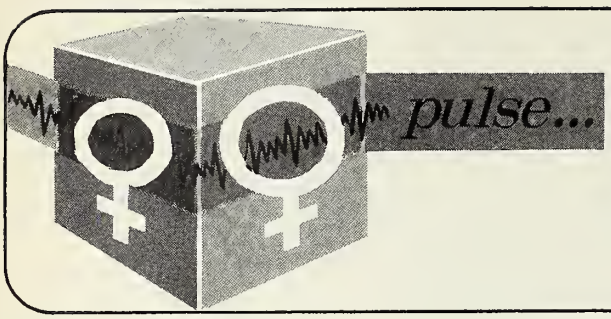
UROLOGY TODAY

For: Urologists. Symposium, April 10, 1974, Indianapolis, Ind.

Hrs. of Instr.: 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35.

Sponsor, contact: Mr. John Roscoe, Indiana Univ. Sch. Med., 1100 W. Michigan Ave., Indianapolis, 46202.

UNIVERSITY OF ILLINOIS



pulse... of the doctor's wife

Mrs. Rosanne K. Frank, *Editor*

Message From President...

What is a convention? It's a gathering, a collection, a get-together, and an assembly of persons of similar interests for the purposes of conducting business, exchanging ideas, learning, and the extension of friendship.

Our convention, **April 3, 4 and 5, 1974,** will also be a discovery. It will be star-studded, a never-before meeting of a galaxy of "stars."

Will we see you, one of our "stars" at convention? Please plan to come.

Mrs. Robert (Bea) Hartman,
WA/ISMS President

Children and Youth

As Co-Chairman of the Children and Youth Committee my responsibility is mainly representing the ISMS Auxiliary at the Illinois Commission on Children's meetings with Members of Statewide Cooperating Organizations Committee and Contacts of Statewide Cooperating Organizations Relating to the White House Conference.

Because "those crucial years are more crucial than you thought," in the development of a child's potential, all aspects affecting the growth and development of children are considered from the standpoint of what needs to be done and what actions need to be taken.

A few of the areas of concern involving the care of the children of Illinois include:

functions of the Department of Children and Family Services; program services; child abuse; placement of children; Juvenile Courts and the Children's Legal Rights; provisions of court services for wards of the court; adoption procedures and regulations, and the role of the Mental Health Department, etc.

"CHILDREN'S RIGHTS" is receiving increased attention. In addition to juvenile misbehavior, both criminal and non-criminal, the project will consider how the rights of children should differ from those of adults. Presently, laws vary greatly in the manner in which they regulate such matters as children's opportunity to receive medical care without parental permission, their access to information about sex and birth control and the age at which juveniles may make contracts or incur other legal obligations.

Have you made a study of the care of children in your county? Do you know what services are provided, and what laws exist? What do the children of your community need? With the proper rearing of our children each child's fullest potential may be developed so there can be hope for future generations. In Illinois, let us help each child become a vigorous, secure, loving and healthy social person.

Mrs. Wendell F. (Eunice) Roller
Co-Chairman, Children & Youth Committee

Health Education

Services covered under Health Education can best be remembered by the word AMEN. This includes: **A**ging and Homebound, **M**ental Health, **E**cology and **N**utrition.

Aging and the Homebound becomes a greater problem in our communities as our population increasingly grows older. The National Auxiliary has developed certain programs within this area which we, as states, through our Counties can implement. Some of these programs are:

1. The Volunteer Friendly Visitor Service which makes services available to all in need. These volunteers should be trained, but should perform as "private friends." The volunteer may visit or take a senior citizen on short excursions. The major contribution is for the visitor to talk and LISTEN carefully to the person they are visiting.

2. The Telephone Reassurance Service is another Auxiliary project. The assigned telephone contact person is to call someone daily to see if they are all right and to see if there is anything specific they need. People needing this service are referred by agencies and also self-referred.

3. Home Centered Health Care provides temporary and permanent homemaker aid for people needing such services. This project may be developed in conjunction with other agencies.

4. Project Re-Entry is a stroke rehabilitation and re-entry program started by an Auxiliary in California. Younger people are suffering more strokes, as well as our Senior Citizens. Help is needed in occupational, speech and physical therapy. This program could be undertaken jointly with the Heart Association in Illinois.

5. The Handyman Service is an employment referral for Senior Citizens who are still active and are interested in doing odd jobs. There is a wealth of talent to be tapped in our retired people.

6. Day Care for the Elderly is offered through Mental Health agencies or Senior Citizens Centers. This is a much needed service which can be coordinated through other groups.

Mental Health always has been a concern of Medical Auxiliaries since statistics show that one out of every ten persons has some problem in this area. Children show this same statistical evidence. The major priorities and concerns are:

1. With children, our emphasis should be on their development, services to them and parent education.

2. Drug abuse is a constant problem with alcoholism still the number one enemy. Cooperation with other agencies is our best source of aid.

3. A survey of your county needs is a great MUST. We are charged to survey the community in regards to: a) prevention, b) treatment; and c) rehabilitation.

New programs are being developed but of special interest is:

1. **Inside Out** which is a series of 30 films narrated by Shari Lewis and funded by Exxon. The films cover childhood problems at the child's level and is shown over public TV. It has a "guidebook" for teachers to lead group discussions.

2. **Echoes of Childhood** is a follow-up for children who have experienced the **Inside Out** series.

3. Legislation concerning the "rights" of the mentally ill is needed. Check your state laws and be aware.

A relatively new area of concern to the Auxiliary is ecology. The Environmental Protection Agency has a package program available. They are also coming out with a film that can be secured from their regional office in Chicago.

Nutrition is an area where we can be of some assistance. Home delivered meals is an established Auxiliary project. Group meals where a center is provided for daily feeding of the elderly provides good nutritious meals at a reasonable cost plus daily sociability. Child and teenage nutrition education is needed.

The lack of food is a big concern. It is estimated that 5,000,000 children go to bed hungry in our country. The National School Lunch Program has helped considerably.

Quaker Oats Company will give nutrition demonstrations of an educational nature. They are excellent and are directed to all ages and economic groups. New and recommended books are Food and Physical Fitness by Blue Cross and the AMA Let's Talk About Food by Philip White, M.D.

The big push in nutrition education is going to be labelling. This as a project all Auxiliary members can be a part of through their letters to newspapers, legislators, etc. Foods should be properly and uniformly labelled for contents. ◄

**Reported from North Central Regional Workshop and National Fall Conference of WA/AMA by Elizabeth Davis and Mickey Glatter.*

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

ALBION: Population 2,000. Family Physician for community located in Southern Illinois in Edwards County with doctor-patient ratio of 1:3500. Located one hour from metropolitan area. Office space available. Financial assistance available. Contact: Don Broster or Jerry Wiseman, Citizens National Bank of Albion, 618-445-2344. (4)

AMBOY: Population 2,200. Shopping area—approximately 6000. Located 100 miles west of Chicago; just south of the East-West Tollway. Office space available. Year 'round recreation. Complete downtown shopping areas. Contact: Larry G. Hawes, 220 East Main St., Amboy, 61310, 815-857-3625. (4)

BERWYN: 5 Emergency Room Physicians needed. 442-bed hospital; suburban Chicago. Patient diagnosis, management and disposition. University of Illinois Abraham Lincoln School of Medicine appointment available. 3 years emergency experience or emergency medicine residency (other residencies considered). Contact: Kenneth Kessel, M.D., E.R. Director, MacNeal Memorial Hospital, Berwyn, 60402, 312-787-300. (4)

BLUE ISLAND: Gastroenterologist, Opthalmologists and Otolaryngologist urgently needed in this south suburban community. City of approx. 20,000, but hospital and clinic serving approx. 250,000. Pronger-Smith Clinic, old, well-established clinic in beautiful new building. Generous starting salary. Contact: Gerald A. Caress, 2320 W. High St., Blue Island, 60406, 312-388-5500. (2)

BUSHNELL: Doctors! ! ! The pot of gold at the end of the rainbow is at Bushnell. Contact: Jack Gordon, 462 East Main St., Bushnell; call collect 309-733-3141. (6)

CARBONDALE: 30 man multispecialty group. University community with medical school. Mild climate with recreational facilities. Drawing area of 500,000. Contact: Dr. Donald Darling, Carbondale Clinic, Carbondale, 62901, 618-549-5311. (4)

CARLINVILLE: City population 6000. County seat serving 25,000. Six physicians in city. 68-bed general hospital. Midway between Springfield, Ill. and St. Louis—one hour drive. Financial assistance available. Contact: Jim Rives, P.O. Box 35, Carlinville, 62626, 217-854-3141. (4)

CARROLLTON: Ample excellent opportunities in Greene County for Family Physician. Group practice being set up in new office accommodating 4-5 M.D.s next to hospital. For further information, contact: Dr. Caselton or Dr. Chung or Roy Shoemaker in Carrollton, 62016, 217-942-6946. (4)

CARTHAGE: County seat of Hancock County; population 24,000. Need Family Practitioners, Radiologist, Pathologist, Internist. Opportunity for solo or group practice. Minimum guaranty offered by 130-bed hospital and nursing home. State University nearby. Contact: Harold A. Dietz, Administrator, Memorial Hospital, Carthage, 62321, 217-357-3131. (4)

CHENOA: Rural area, 100 miles south of Chicago on I-55. Looking for one or two physicians to do family practice. Hospital facilities nearby. Financial assistance and office space can be arranged. Contact: R. J. Walker, National Bank of Chenoa, Chenoa, 61726, 815-945-2311. (4)

CHICAGO: Young multispecialty group with 4 locations. 24 physicians at present. Need Family Physicians or General Internists. Hospital appointments assured. Financial reward comensurate with effort. Opportunity to grow with group. Contact: Dr. Arthur Kunis, 3157 W. Lawrence Ave., Chicago, 60625, 312-478-1939. (6)

CHICAGO: Openings for Medical Specialists and General Practitioners. We are seeking clinicians and supervisors to provide comprehensive health care to City residents through network of Neighborhood Health Centers. Competitive salaries, complete fringe benefits. Contact Mr. Gerald O'Sullivan, Personnel Office, Board of Health, Civic Center, Chicago, 60602, 312-744-3805. (3)

CHICAGO: Privately owned clinic, south side. 44-hour week. No night work. Contact: Robert C. Parro, Professional Medical Center, Inc., 104 E. 51st St., Chicago, 60615, 312-268-3400. (4)

CLINTON COUNTY: Population 28,400. 35 miles east of St. Louis. General Practitioner, Pediatrician, Internist. New 104 bed modern, progressive hospital. Office facilities and financial assistance available. Excellent school and friendly people. Beautiful Carlyle lake minutes away. Contact: John Rehkemper, RR 2, Highland, 618-654-3527. (6)

CHRISTOPHER: Area population 20,000. Office facilities for two family physicians. New hospital and nursing home being built in Christopher. Financial assistance available. New subdivisions, excellent schools, churches. Heart of five new lakes and recreation areas. Near Southern Illinois University. Contact: Jeff Troutt, Box 5, Christopher 62822, 618-724-2928. (4)

COLFAX: Population 978. One physician at present who desires another doctor to occupy remaining portion of new clinic. Twenty-five miles from Bloomington. Financial assistance available and housing available. Recreational facilities nearby. Contact: Don Wilber, Colfax, 309-723-4671, or Michael Payne, 212 East Washington Street, Bloomington, 61701, 309-829-6344. (6)

DIXON: Internist-General Surgeon—board certified/board eligible. Recently established multi-specialty clinic with close affiliation to a 200 bed hospital offers opportunities to build a large practice in both of these specialties. $40,000 a year guarantee plus fringe benefits and opportunities that are quite challenging. Progressive rural community offers a unique family oriented environment. No traffic problems, clean air, and excellent recreation areas combine to provide the "good life." Only 1 hr. 15 min. from Chicago allows easy access for exposure to academic medicine. Phone collect—John Tatum, Administrator, Medical Arts Clinic, Dixon, 61021, 815-288-5531. (4)

Obituaries

***Edwards, Gilbert H.,** Ft. Myers, Fla., died November 16, 1973, at the age of 69. Prior to his retirement to Florida, Dr. Edwards practiced in Pinckneyville for 35 years. He served as President and Secretary of the Southern Illinois Medical Association and the Illinois OB-GYN Society. He was a graduate of the University of Illinois College of Medicine.

Gowdy, Franklin K., Glencoe, died July 15, 1973, at the age of 70. He graduated from Rush Medical College.

***Green, George,** Metropolis, died November 8, 1973, at the age of 57. He graduated from the Chicago Medical School in 1941. Dr. Green practiced medicine in Brookport from 1943 to 1945 and since then in Metropolis.

***Gulick, Joseph Lee,** Muncie, died December 8, 1973, at the age of 39. He graduated from the University of Illinois College of Medicine in 1959. Dr. Gulick was a staff member of both St. Elizabeth and Lake View Memorial Hospitals. During his medical career he was Chairman of the Danville Practicing Nursing School Advisory Committee; Associate Dean for Graduate Education in the School of Basic Medical Sciences of the University of Illinois and Board Member of the East Central Illinois Medical Education Foundation.

***Houck, Virgil L.,** Bloomington, died July 27, 1973, at the age of 47. He was on staff at the Mennonite Hospital.

***Jachimowski, Tedfield C.,** Chicago, died December 2, 1973, at the age of 66. He graduated from the Chicago Medical School in 1935.

****Jones Clarence Kenneth,** Chicago, died November 8, 1973, at the age of 84. He graduated from the University of Indiana in 1919.

Kersey, George Thomas, Chicago, died August 25, 1973, at the age of 66. He graduated from the University of Illinois in 1934.

****Kramer, Maurice D.,** Chicago, died December 4, 1973, at the age of 88. He graduated from Loyola Stritch School of Medicine in 1918.

Lai, Daniel G., Forest Hills, died August 27, 1973, at the age of 76. He graduated in 1925 from Rush Medical School.

****Marmor, Samuel,** Chicago, died December 1, 1973, at the age of 81. He graduated from Loyola Stritch School of Medicine in 1914.

Morrison, Donald, Winnetka, died July 28, 1973, at the age of 67. He served on the faculty of the Rush Medical College and the University of Illinois College of Medicine.

***Shapiro, Bernard,** Chicago, died October 17, 1973, at the age of 74. He graduated from Northwestern University School of Medicine.

****Simmonds, Walter E.,** Oak Park, died October 11, 1973, at the age of 89.

***Strohl, E. Lee,** Chicago, died December 30, 1973, at the age of 67. A graduate of the University of Illinois College of Medicine, Dr. Strohl served as Board President of the Municipal Tuberculosis Sanitarium. He was a member of the Chicago Board of Health and served on the Board of Governors of the American College of Surgeons. Dr. Strohl had been the senior attending surgeon at Rush Presbyterian-St. Luke's and an attending surgeon at Cook County Hospital.

****Wahl, Eugene Frank,** Edwardsville, died October 28, 1973, at the age of 91. He graduate from Washington University, St. Louis, in 1906.

**Denotes member of ISMS*
***Denotes member of 50-year Club and ISMS*

President's Page

(Continued from page 95)

by constantly escalating costs and inefficient administration. It cannot be denied that Medicare, which was a product of the mid-1960s, enjoyed tremendous public support. But a now disillusioned public did not forsee the tremendous expenditures and inefficiency which plague the program today.

The Veterans Administration, with a health care system wholly controlled by the government, is hampered by an unwieldy bureaucracy which appears at times to accept care of questionable quality. Last July, the House Veterans Affairs Committee charged that VA hospitals were not adequately staffed; an obvious indication of inadequate care for our veterans. The care is inadequate, of course, only for those fortunate enough to overcome bureaucratic blunders and receive care at all.

Recently, an Illinois veteran of the Vietnam war whose face was literally blown off in combat received needed medical attention only because VA bureaucrats were goaded into action by a direct order from President Nixon who had read in a Chicago newspaper about the veteran's plight.

Now we are confronted with government's latest cure-all—PSRO—allegedly aimed at insuring the quality of medical care. Strangely, however, the law mainly addresses itself to cost control. Past failures of government programs should provide the public and the medical profession with sufficient warning. We must present a united front against potential fiascos peddled to the public as magical solutions to major problems.

We must stand united in our response to the directives of the House of Delegates.

William e. Screws M.D.

UNIVERSITY OF ILLINOIS

CLASSIFIED ADVERTISING

Positions & Practice Opportunities

WANTED: OB-GYN, SURGEON and INTERNIST for nine man group. Thirty miles southwest of Chicago, excellent hospital, housing and schools. $30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

FAMILY PRACTICE OPENING—January, 1974 in two man office. Cashmere, Washington, outstanding orchard community. Scenic area with unlimited recreation opportunities. Partner retiring. Initial salary and early partnership. Edgar A. Meyer, M.D. (Iowa '50) ABFP, 303 Cottage Ave., Cashmere, Washington 98815.

ATTENTION PHYSICIANS! CHICAGO MEDICAL CENTERS—Welfare area in need of physicians. Please contact: Mr. Robert Fields (312) 236-2555.

GENERAL INTERNISTS and **GENERALISTS:** For growing sub-sections of 45 man medical department, including allergists, psychiatrists, neurologists, all sub-specialties and expanding primary care section. Multispecialty group of 120. Large patient population and area referral. Functioning HMO. Generous salary and fringe benefits. Peaceful setting near Wisconsin vacationland and cities. Good schools, cultural advantages, Junior College. Educational and research programs. Liberal schedules, little practice pressure. New Clinic and hospital developing. Write or call J. L. Struthers, M.D., Marshfield Clinic, Marshfield, Wisconsin 54449.

INTERNIST or **GENERAL PRACTITIONER:** An insurance company has an opening for the position of Staff Physician in its Medical Department in Chicago. Full time. Fringe benefits. Salary negotiable. Office population. Send curriculum vitae to Box 823, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

WANTED: FAMILY PRACTITIONERS, PEDIATRICIANS, INTERNISTS, and **OBSTETRICIANS** for dynamic municipal Midwest Health Department providing innovative primary care. Faculty appointment available. Salary $27,500-$30,000 negotiable. Must be eligible for Ohio license. Reply P.O. Box 238, Cincinnati, Ohio 45202.

Two Board certified or eligible **OB-GYNES** are wanted to take over the practice of two retiring members of a busy OB-Gyne practice. Remaining OB-Gyne man needs help in a rapidly growing community of 80,000, 40 miles west of Chicago. Contact George J. Shimkus, M.D., Aurora Women's Clinic, S.C., 143 So. Lincoln Avenue, Aurora, Illinois 60505.

INTERNIST WANTED, Occupational Medicine Department, Chicago. Office employee population. Regular hours. No work nights or weekends. Excellent fringe benefits. Salary negotiable to mid-thirties. Send curriculum vitae to Box 824, c/o Illinois Medical Journal, 360 North Michigan Avenue, Chicago, Illinois 60601.

PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT and Emergency Room. Become a part of an expanding, dynamic multispecialty clinic in Midwest University community. Excellent salary benefits. Write or call Medical Director, Carle Clinic, Urbana, Illinois 61801. Phone (217) 337-3239.

GENERALIST AND INTERNIST wanted to fill vacancies in Major Chicago Area Hospital. Associated with Medical Schools in Chicago. Salary Competitive. 40 hr. work wk. with excellent fringe benefits which include: vacation, paid sick time, holidays, pension plan, tuition reimbursement. Must be licensed in Illinois. Contact: Ms. L. Johnson, Employee Relations, Oak Forest Hospital, Oak Forest, Illinois 60452.

PHYSIATRIST—Major Chicago Area Hospital has openings available for Board certified or eligible physician to assume position in recently established Rehabilitation Center. 40 hour 5 day week with excellent fringe benefits. Contact Ms. L. Johnson, Employee Relations, Oak Forest Hospital, Oak Forest, Illinois 60452.

Positions & Practice Opportunities (Con't)

PHYSICIAN WANTED: SPANISH SPEAKING M.D., For New Chicago area medical center. Phone: (312) 967-1374. After 6 p.m.

FAMILY PRACTITIONERS, INTERNISTS and PEDIATRICIANS: Full time salaried appointment to Medical Staff at Cook County Hospital with opportunity to practice half time or more in a community clinic. Write or call David McL. Greeley, M.D., Health and Hospital Governing Commission, 1900 West Polk Street, Chicago 60612, phone 633-8825.

FAMILY PRACTITIONERS—Expanding 880 bed multiple facility medical center in Chicago is seeking family practitioners (individual or groups) to join the staff of its family practice oriented facility—230 bed hospital located on the near West Side. The hospital will provide an office and furnish equipment to establish private practice at a mutually agreeable site in the nearby community—no investment by physicians required—and guarantee annual private practice income to a $36,000 minimum for one to five years (negotiable). Send Curriculum Vitae to Box 825, c/o Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Illinois 60601.

OZAUKEE COUNTY NEEDS Family Practitioners, Orthopedist, and Pediatricians to provide health care for over 55,000 affluent people. St. Alphonsus Hospital, located in the center of Ozaukee County, is an orderly, modern facility ready to provide acute hospital care. Office space is available here and in nearby cities and villages. Contact George A. Seidenstricker at St. Alphonsus Hospital, 743 North Montgomery Street, Port Washington, Wisconsin 53074. Phone 414-284-5511.
P.S. Spend the day with us so we can show you and your family everything . . . schools, shops, homes, parks.

Emergency and Acute Care Physicians needed by expanding partnership of practitioners. Initial remuneration $52,000.00. Potential advancement on merit basis to $74,000.00 after two years. Box 826, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, 60601.

FOR SALE, LEASE OR RENT

PROFESSIONAL OFFICE FOR SUBLEASE, part-time or full-time, in brand new professional building, Downers Grove. Waiting room, consulting room, wash room. Contact: A. Guschwan, M.D., 2112 West Jefferson, Joliet, Illinois 60435. Phone (815) 725-1188.

FOR RENT: NORTH SIDE CHICAGO 3 ROOM OFFICE SUITE with reception room. Air conditioned. Janitor service, 1046 Wilson Avenue, Chicago, Illinois. Telephone: Agent, David C. Goldfine (312) 321-9380.

FOR RENT: Suites available in a recently completed Medical Center just ½ Mile from the new proposed Hospital in Barrington, Illinois. Each suite, 800 sq. ft., is elegantly finished and absolutely indedendent, incl. W/R, A/C, AM-FM, etc. Ample parking. Reply Box Number 815, c/o Illinois Medical Journal, 360 North Michigan Ave., Chicago, Illinois 60601.

FURNISHED OFFICE SPACE FOR RENT—reasonable, available in the South Shore area of Chicago. Immediate possession and patient load for Medical Doctor. No need to buy practice. Contact Mr. Feffer: (312) 493-7733.

OUR NEWEST OFFICE COMPLEX is now leasing its medical building. Custom built suites overlook a beautiful golf course. In this above average income area; our rents are reasonable, including a generous decorating allowance. Two minutes from a major Joliet hospital Brochure available. Venterra Inc., 3033 West Jefferson, Joliet, Ill. 60435.

FOR RENT—OFFICE and RESIDENCE: Located minutes from O'Hare Field in an exclusive community, this home is ideal for a large office in the home set-up. It borders a private, spring-fed stocked lake. The four-to-six bedroom home has huge living, family and basement party rooms, with a total of 16 rooms and 7,000 feet of living space. Beautifully landscaped by Chalet (at $30,000 cost). Three-car garage, sauna, billiard rooms. Architect: Art Swanson, designer of O'Hare Inn. Partial Trade Possible. $258,000—Write for details, 141 N. Dee Road, Park Ridge, Illinois 60068.

BLUE SHIELD REPORT FOR *Illinois Physicians*

Spring Series of Workshops For Medical Assistants Begins in April

Arrangements for the Spring schedule of workshops for medical assistants in central and downstate counties of Illinois have been made by the Blue Shield Plan of Illinois Medical Service, with the first meeting to be held April 3 in Mt. Vernon, Illinois.

Daytime meetings will again consist of morning and afternoon workshop sessions. Two evening meetings have been scheduled, one April 24 in Decatur and the other May 1 in Rockford.

Registration for the morning workshop programs will begin at 9:30 AM and sessions will continue until noon, followed by a luncheon for all participants attending either morning or afternoon sessions. The afternoon programs will begin at 1:15 PM and conclude at about 4:00 PM. The two evening workshop sessions will begin with dinner promptly at 6:30 PM, and the meetings concluding at 9:00 PM.

Members of our Professional Relations Department will conduct the workshops. Discussions and instructional material will include the new Blue Shield 2-part voucher form on member Notification of Benefits Paid, the State of Illinois Employees' program and the Reciprocity Program.

Invitational letters to all physicians' offices in central and downstate counties will be mailed by March 15.

For additional information, please write or telephone Mrs. Loretta O'Donnell, Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 233 North Michigan, Ave., Chicago, Illinois 60601 (312) 661-2964.

The following meetings have been scheduled:

Wed., April 3	Ramada Inn	Mt. Vernon
Thurs., April 4	Ramada Inn	Marion
Wed., April 10	Augustine's Restaurant	Belleville
Thurs., April 11	Holiday Inn	Edwardsville
Wed., April 17	Ramada Inn	Champaign
Thurs., April 18	Ramada Inn	Effingham
Wed., April 24	Decatur Club (dinner workshop)	Decatur
Wed., May 1	Henrici's Restaurant (dinner workshop)	Rockford
Thurs., May 2	Henrici's Restaurant (daytime workshop)	Rockford
Wed., May 8	Ramada Inn	Quincy
Thurs., May 9	Heritage House Restaurant	Pittsfield
Thurs., May 16	Sheraton Inn	Springfield
Wed., May 22	Ramada Inn	Peoria
Thurs., May 23	Holiday Inn	Bloomington
Wed., May 29	Holiday Inn	Macomb
Thurs., May 30	Holiday Inn	Mattoon
Wed., June 5	Sheraton Motor Inn	Rock Island
Thurs., June 6	Sheraton Inn	Galesburg
Wed., June 12	Holiday Inn	Sterling
Thurs., June 13	Ramada Inn	Kankakee

How to Request Physician's Service Report Forms

Because Blue Shield wants to comply with requests from physicians for new supplies of the Blue Shield Physician's Service Report forms as soon as they are received, a procedure has been developed that will be helpful in expediting such requests:

(1) In placing your order for new Physician's Service Report forms, please use the color-coded insert having the name, address and physician's code number in it for identification. The insert is enclosed with every supply of Physician's Service Report forms and will expedite reordering;

(2) If you do not have an insert, please use your office letterhead or billing statement with the order, showing name, address of the physician and his identifying code number if available. Send the request to the Blue Shield office to the attention of the Physicians' Code Section.

(3) Please do not use a copy of the Physician's Service Report form as an order form.

Blue Shield Will Exhibit at Midwest Clinical Conference

Blue Shield invites you to visit our exhibit booth at the Conrad Hilton Hotel during the Midwest Clinical Conference, sponsored jointly by the Chicago Medical Society, the Illinois State Medical Society and participating specialty societies, April 3-6.

The exhibit will be staffed by Professional Relations Representatives of our Plan qualified to answer questions on Blue Shield programs and on Medicare. Literature will also be available on our programs and recent changes in Medicare.

(This report is a service to the physicians of Illinois)

UNIVERSITY OF ILLINOIS

Sources of Laboratory Services Must Be Identified

A recent revision in Medicare instructions issued by the Social Security Administration requires that physicians must identify the sources of laboratory services to avoid delays in processing of Part B claims.

Identification of the laboratory performing the service must be on the SSA-1490 Request for Medicare Payment form or the billing statement submitted to the carrier. If the laboratory performing the service is not identified, the physician will be contacted to determine where the service was performed. Claims that were formerly accepted without a physician's indication that the test was performed in his office will no longer be routinely processed.

When an attending physician providing services in his office includes in his bill services obtained from a laboratory outside his office, the laboratory must also be identified.

(1) When a physician orders tests from an independent clinical laboratory, it must be one certified in its specialty or specialties by the Social Security Administration. The laboratory must also agree to perform tests for patients covered by Medicare only in the specialty or specialties for which it is certified. If it performs a test for which it is not certified the claim for services will be denied.

(2) When a test or other laboratory service is referred from one independent laboratory to another, the laboratory performing the test must be certified in the specialty. The name of the laboratory performing the test should be made known to the physician and identified on the SSA-1490 form.

(3) Screens, profiles and automated tests are covered by Part B Medicare and the test need not be listed with separate charges. However, the name of each test and total charge for the group of tests must be shown on the SSA-1490 form or attached itemized statement.

(4) Physicians may charge a drawing fee.

Denial of coverage for a laboratory test does not affect coverage of the office visit which usually includes the physician's charge for evaluating and interpreting the laboratory report.

Medicare Payment for Psychiatric Outpatient Services

Coverage under Medicare Part B includes outpatient psychiatric services, but payment for these services is limited. Regardless of the actual expenses for physicians' services provided in diagnosis and treatment of mental, psychoneurotic or personality disorders of non-hospitalized patients, the recognized limit by Medicare in a calendar year is $500. The maximum Medicare payment is $250 over that period, after the deductible of $60 has been met.

Payment of services is based on the 62.5 percent rule applied to the $500 maximum expenses limit ($312.50). Any amount of outpatient psychiatric expenses in excess of this would not be considered in computing benefits. When the allowable charge is below $500, payment is determined by taking 62.5 percent of the charge, less any portion of the unmet deductible, multiplied by 80 percent of the remaining charge.

As an example, a patient had undergone psychiatric treatment from January to August 1973 and incurred total expenses of $600 on an outpatient basis. The benefit payable is computed as follows: $500 is the limit that can be considered for reimbursement. This amount is multiplied by 62.5 percent to arrive at the $312.50 figure determined above. The patient had not, during the calendar year, met any part of the Part B Medicare deductible. Therefore, the $60 deductible is subtracted from $312.50, leaving $252.50. The Medicare payment is $202 (80 percent of $252.50).

Expenses in the last three months of 1973, for example, which were applied to the deductible for that year could apply to the deductible for 1974 under the deductible "carry-over" rule.

Medicare specifies that the limitation is applicable to services furnished in a physician's office, the patient's home, an extended care or similarly approved facility, as well as any items or supplies furnished by the physician in his own office. No distinction is made between the services of psychiatrists or non-psychiatrist physicians.

There is no psychiatric limitation on inpatient psychiatric services. These are paid on the basis of 80 percent of the allowable charge after meeting the $60 deductible for services provided during the year.

Services of Physicians' Assistants

There is no provision under Medicare which authorizes payment for services of Physicians' Assistants. The only basis for covering their services under Part B would be those furnished "incident to" a physician's professional service.

One of the requirements that must be met is that services are of the kind commonly furnished in physicians' offices. This limits coverage to services of nurses and other office assistants necessary to the physician's in-office service. Thus, the performance by a physician's assistant of services which traditionally have been reserved to physicians cannot be billed, even though all the other incident-to-requirements are met.

The physician might render a service which is covered even though payment could not be made for the service rendered by the assistant. For example, an office visit charge by the physician that included non-covered services by a physician's assistant, may be reimbursed if the physician himself sees the patient and also makes an independent evaluation of the patient's condition.

IMJ

Illinois Medical Journal

MARCH, 1974 Vol. 145, No. 3 CONTENTS

Convention

196 Delegates and Alternates

204 Agenda for the House of Delegates

205 Reference Committees of the House

207 Annual Reports

- 207 Officers and Administration
- 215 Committees of the Board
- 218 Direct Reporting Committees
- 220 Ancillary Organizations
- 224 ISMS Councils

254 Resolutions

263 Program Summary

(Index on page 194)

Special Article

268 MEDICHEK—The Illinois Program of Early Periodic Screening, Diagnosis and Treatment—What Is It?
Joyce C. Lashof, M.D.

Surgical Grand Rounds

274 Intussusception in an Adult
John M. Beal, M.D.

(Contents continued overleaf)

Features

171 President's Page

180 Clinics for Crippled Children

185 Editorial

186 EKG of the Month

189 Illinois Society, American Association of Medical Assistants

190 New Pharmaceutical Specialties

265 Doctor's News

272 ISMS Guide to Continuing Medical Education

277 Membership Forum

279 Pulse of the Doctor's Wife

283 Physician Recruitment

286 Obituaries

(Cover by Mike White & Associates)

Staff

Editor **Theodore R. Van Dellen, M.D.**

Managing editor **Richard A. Ott**

Assistant editor **Joyce Gallagher**

Executive administrator **Roger N. White**

PUBLICATIONS COMMITTEE

Jacob E. Reisch, M.D., Springfield, *Chairman*
Eugene T. Hoban, M.D., Oak Park
Frederick E. Weiss, M.D., Harvey
James A. McDonald, M.D., Geneva
Warren W. Young, M.D., Crete

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Medical Progress: Harvey Kravitz, M.D., Skokie
Contributor in Maternal Death Studies: Robert Hartman, M.D.
Contributor in Pediatric Perplexities: Ruth A. Seeler, M.D., Chicago
Contributor in Trauma Medicine: David Boyd, M.D.C.M., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood

ILLINOIS STATE MEDICAL SOCIETY

360 N. Michigan Ave., Chicago, 60601

OFFICERS

Willard C. Scrivner, M.D., President
6600 West Main, Belleville 62223

Fredric D. Lake, M.D., President-Elect
1041 Michigan Avenue, Evanston 60202

Paul W. Sunderland, M.D., 1st Vice-President
214 N. Sangamon St., Gibson City 60936

Charles J. Weigel, M.D., 2nd Vice-President
7579 Lake Street, River Forest 60305

Jacob E. Reisch, M.D., Secretary-Treasurer
1129 S. 2nd Street, Springfield 62704

HOUSE OF DELEGATES

Andrew J. Brislen, M.D., Speaker of the House
6060 S. Drexel Blvd., Chicago 60637

James A. McDonald, M.D., Vice-Speaker
13 South Second Street, Geneva 60134

TRUSTEES

Chairman of the Board: William M. Lees, M.D.
6518 North Nokomis, Lincolnwood 60646

1st District: 1974, Joseph L. Bordenave, M.D.
1665 South Street, Geneva 60134

2nd District: 1974, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364

3rd District: 1976, David S. Fox, M.D.
20829 Greenwood Center Court, Olympia Fields 60461

3rd District: 1976, Robert T. Fox, M.D.
2136 Robin Crest, Glenview 60025

3rd District: 1975, Eugene T. Hoban, M.D.
6429 North Avenue, Oak Park 60302

3rd District: 1975, Joseph H. Skom, M.D.
707 Fairbanks Ct., Chicago 60611

3rd District: 1974, William M. Lees, M.D.
6518 North Nokomis, Lincolnwood 60646

3rd District: 1974, George Shropshear, M.D.
1525 East 53rd Street, Chicago 60615

3rd District: 1974, Philip G. Thomsen, M.D.
13826 Lincoln Avenue, Dolton 60419

3rd District: 1976, Frederick E. Weiss, M.D.
15643 Lincoln, Harvey 60426

3rd District: 1975, Warren Young, M.D.
3450 Haweswood Drive, Crete 60417

4th District: 1976, Fred Z. White, M.D.
723 North 2nd Street, Chillicothe 61523

5th District: 1976, A. Edward Livingston, M.D.
326 Fairway Drive, Bloomington 61701

6th District: 1975, Mather Pfeiffenberger, M.D.
State and Wall Streets, Alton 62002

7th District: 1976, Arthur F. Goodyear, M.D.
142 East Prairie, Decatur 62523

8th District: 1976, Eugene P. Johnson, M.D.
P.O. Box 68, Casey 62420

9th District: 1975, Warren D. Tuttle, M.D.
203 North Vine Street, Harrisburg 62946

10th District: 1975, Herbert Dexheimer, M.D.
301 S. Illinois, Belleville 62220

11th District: 1974, Joseph R. O'Donnell, M.D.
444 Park, Glen Ellyn 60137

Trustee-At-Large: Frank J. Jirka, Jr., M.D.
1507 Keystone, River Forest 60305

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/ Clinical Practice.*

Published by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601 (312-782-1654)

Copyright, 1974. The Illinois State Medical Society.

Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail).

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.



The Physician— Public Defender of American Health

As physicians *we are vitally concerned about the welfare of our patients.* However, this concern sometimes may cloud our awareness of an equally vital role we must fill: public defender of American health.

Our training and experience undeniably rank us as best qualified to judge the effectiveness of programs presumably designed to meet the health care needs of the public as well as our individual patients.

By accepting the role of defender of American health, we have assumed a responsibility to initiate workable programs, and to vigorously oppose cure-all "paper" proposals unilaterally enacted by self-serving bureaucrats.

In recent years we have accomplished much, yet much more needs to be done. Let's look at some of medicine's accomplishments in Illinois. We have:

- *Worked* for licensing of ambulatory treatment centers which provide the public with an alternative to costly, unnecessary hospitalization for minor surgery.
- *Seized the opportunity* to assist in implementing a comprehensive program aimed at identifying, diagnosing and treating health problems of Medicaid-eligible children. Will, Grundy and Kankakee Counties have been selected as the site for a pilot project to demonstrate how individual physicians, utilizing the expertise of medical organizations, can effectively implement government's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements. Project results will be used by the AMA to develop a guide for provider involvement in EPSDT which HEW will use throughout the nation.
- *Fought tirelessly* in the legislative arena to pass legislation beneficial to public health, and to defeat proposals we believed harmful.
- *Supported medical education* by contributing nearly $4 million to the AMA-ERF.
- *Helped deserving students* gain admission to the University of Illinois Medical School through our Student Loan Fund program.
- *Assisted the Department of Registration and Education in* protecting the public from cultists and other quacks.
- *Formulated a pilot program* with the Council on Community Services of Metropolitan Chicago which would coordinate information about various agencies offering health and welfare services through a 24-hour "hotline" telephone service.
- *Conducted "Doctor's Job Fairs"* in addition to our placement service and put physician-short communities in contact with MDs interested in relocating or establishing new practices.
- *Encouraged medical students to locate in Illinois* communities by exposing them to the practice of medicine in these areas through the Medical Education Community Orientation (MECO) program.
- *Established clinics* to meet the immediate health care needs of the poor and provide them with an entry point into the health care system.

These, and many other noteworthy projects, deserve our continued support in the years ahead. But we also must attempt to improve the health care of two neglected classes of Americans—migrant workers and Indians.

We urge state government to initiate programs to meet the health care needs of the Indian population in Illinois. These people suffer from inadequate care because of cultural differences and inability of the reservation-oriented U.S. Indian Health Service to meet the needs of Indians residing in urban areas.

We must increase our efforts to provide better care for migrant workers. Physicians in Peoria County have demonstrated what can be done to aid migrants, and to provide access into the health care system after they travel to other areas.

(Continued on page 281)

Unity + Strength = Effectiveness



The irritations of man's day are often reflected in his gut.

The causes of irritable colon and the diarrheal symptoms that often accompany it can be as diverse as the systemic and emotional irritations man is faced with daily.

Although the mucoid nature of stools and the occurrence of diarrheal episodes coincident with times of emotional stress may be valuable clues to the functional nature of the disorder, irritable colon must often be diagnosed by exclusion. Such diagnostic exploration takes time. Discovery of the nature of any emotional problems may take more. During that time, Lomotil® is an ideal agent for controlling diarrheal symptoms.

Lomotil tablets are small, easy to carry and easy to take. They act promptly and effectively. Secondary effects are relatively infrequent and, once the first force of the diarrhea is controlled, maintenance is frequently effective on as little as one fourth of the initial dosage.

These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.

Physicians like the kind of prescriptions we write.

When a physician comes to us to borrow money, he gets the kind of treatment he deserves. We don't think it's necessary to ask a lot of involved or embarrassing questions.

Even if you want to borrow important money, like $15,000 for new equipment. Or enough to buy that luxury item you've always wanted, take a long vacation, or for any other purpose you desire.

We promise you preferred rates with no red tape or hassle. Tell us what kind of deal you want, and we'll try to work it out for you.

For some uncomplicated financial help, call Jim Shea at (312) 661-5841. He's one of the people who makes the difference at American National.



And he's ready to give you our special treatment..

American National Bank and Trust Company of Chicago
The Idea Bank

LaSalle at Washington 60690 • LaSalle at Wacker 60601 • Phone (312) 661-5000
Member FDIC

Clinics Listed For Crippled Children During April

Twenty-nine clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 21 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

April 2 East St. Louis—Christian Welfare
April 2 Quincy—St. Mary's Hospital
April 3 Metropolis—Massac Memorial Hospital
April 3 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
April 3 Hinsdale—Hinsdale Sanitarium
April 4 Sterling—Sterling Community Hospital
April 4 Lake County Cardiac—Victory Memorial
April 5 Chicago Heights Cardiac—East Chicago Heights Community Center, Inc.
April 8 Peoria Cardiac—St. Francis Children's
April 9 Peoria—St. Francis Children's
April 10 Champaign-Urbana—McKinley Hospital
April 11 Effingham—St. Anthony Memorial
April 11 Springfield—St. John's Hospital
April 11 Cairo—Public Health Department
April 11 Kankakee—St. Mary's Hospital
April 15 Peoria Cardiac—St. Francis Children's
April 16 East St. Louis—Christian Welfare
April 16 Rock Island—Moline Public Hospital
April 17 Chicago Heights—East Chicago Heights Community Center, Inc.
April 18 Rockford—Rockford Memorial Hospital
April 18 Bloomington—Mennonite Hospital
April 18 Elmhurst Cardiac—Memorial Hospital of DuPage County
April 23 Peoria—St. Francis Children's
April 24 Springfield Ped-Neuro—Diocesan Center
April 24 Centralia—St. Mary's Hospital
April 24 Aurora—St. Joseph Mercy Hospital
April 26 Evanston—St. Francis Hospital
April 26 Chicago Heights Cardiac—East Chicago Heights Community Center, Inc.
April 30 Mt. Vernon—Good Samaritan Hospital

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.
Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.
Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.
The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.
Proloid (thyroglobulin) is stable when stored at usual room temperature.
Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.
In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.
Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.
Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.
Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.
Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.
Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.
Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.
Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.
Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.
(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)
How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.
Full information available on request.
WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950
FR-GP-31-8/W

Editorials



Against Medical Advice

Hospitals are not jails and patients can request a discharge if they wish. However, when they act against the physician's counsel, they are asked to sign an "Against Medical Advice" form before leaving the hospital. Various reasons for wanting to leave are given and, be these valid or invalid, it is usually an unpleasant experience for the staff, doctor, patient, and family.

If the patient is not likely to harm himself by leaving the hospital, the physician may let him go. Nowadays many people complain about the type of care they receive or think they are entitled to. Delays in getting attention and personality conflicts with interns, nurses, and various aides are not uncommon.

Threatening to "sign-out" has more serious ramifications when the individual is extremely ill and might harm himself by leaving. All too often fear is the catalyst. Only the strongest of emotions produce this type of potentially self-destructive behavior. An attending physician who is conscientious and honest will want to know: "What is there in the hospital situation, including me, that has provoked the turmoil this patient now experiences?"

In an effort to find the answers, patients at the Columbia-Presbyterian Medical Center in New York who threaten to sign out against medical advice are asked to consult a psychiatrist. Albert and Kornfeld[1] who reviewed the course of 28 such individuals found three main causes for the threat: overwhelming fear, anger, or psychotic reasons. All individuals surveyed were medical and surgical patients in this general hospital .

Contributing factors also involved breakdowns in communications between patient and physician. Unfortunately, lack of communications caused delays leading to medical crises that were not understood by the frightened or angry individual. Family difficulties and impasses with the staff also occurred.

Albert and Kornfeld concluded that most patients preferred to resolve the problem rather than leave the hospital. When patients complained about the nurses, they were reacting to them as symbolic figures. Unless the nurses understood this, they continued to make it difficult for the patient. Intervention of attending physicians was most helpful.

The situation is different where the patient's anger is a justifiable response to an indifferent staff. Under these circumstances, the physician should admit that the patient's complaint is justified. This satisfies the patient because it means he is still in control of his destiny, even though seriously ill. Not to admit the error only adds to his anger.

Medications are essential in treating psychotic states, but they are not a substitute for improving the patient's surroundings or relationships with the staff. Twelve of the Columbia-Presbyterian group were given appropriate medications before psychiatric consultation. Ultimately, their emotional improvement stemmed from environmental changes and not from the drugs. The psychiatrists found that hospitals were frightening places for patients with intact nervous systems, but terrifying when an organic deficit existed. When this is recognized, hospitalization goes along more smoothly.

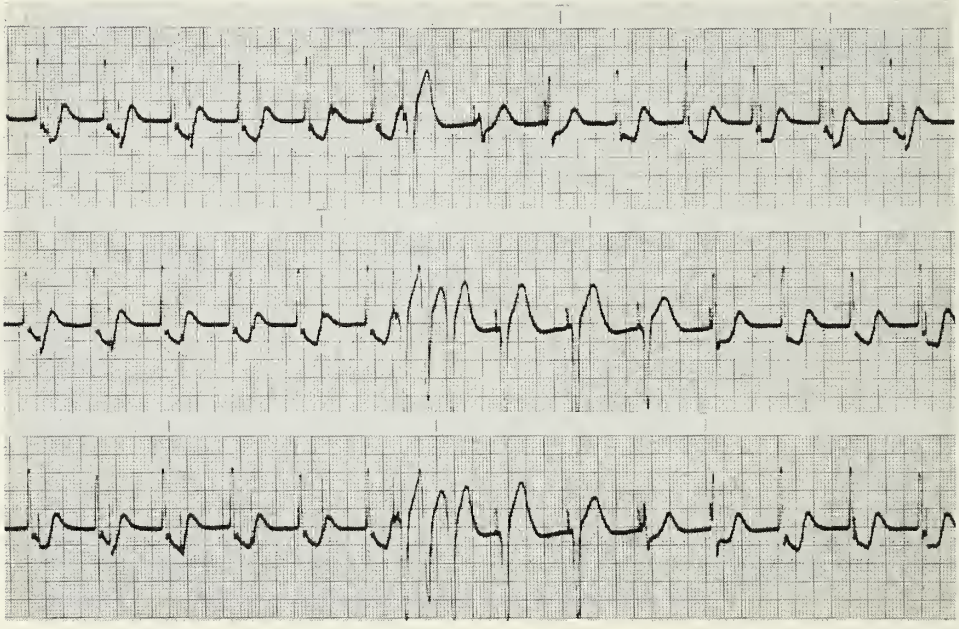
Albert and Kornfeld firmly believe that the physician should resist the temptation to issue an ultimatum denying the patient further care if he leaves. Young interns or residents are more likely to do this and should be advised accordingly. Threats rarely dissuade the patient from leaving and make continuing outpatient treatment less likely.

T. R. Van Dellen, M.D.
Editor

1. Albert, H. D. and Kornfeld, D. S.: "The Threat to Sign Out Against Medical Advice." *Ann. Int. Med* (Dec. 1973, pgs. 888-891).

ekg of the month

John R. Tobin, M.D., M.S., Rimgaudas, Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., James V. Talano, M.D., Sarah Johnson, M.D. and Rolf M. Gunnar, M.D., M.S./Section of Cardiology, Loyola University Stritch School of Medicine



A 72-year-old man presented to the emergency room in complete A-V heart block and congestive heart failure. A temporary transvenous pacemaker was inserted. Digoxin 0.50 mg was given intravenously.

The patient was then transferred to the coronary care unit. The following ECG rhythm strip was recorded about four hours later.

Questions:

1. **The rhythm strip shows:**
 A. Junctional tachycardia.
 B. Pacemaker competition.
 C. Pacemaker induced ventricular tachycardia.
 D. Vulnerable period phenomenon.
 E. All of the above.
2. **The treatment should include:**
 A. Discontinuing digoxin.
 B. Increasing the current stimulus strength (ma.) of the pacemaker.
 C. Turning the pacemaker off.
 D. Giving lidocaine.
 E. None of the above.

(Answers on page 282)



report

Illinois Society
American Association of Medical Assistants

MIDWEST CLINICAL CONFERENCE MEDICAL ASSISTANTS SEMINAR

Conrad Hilton Hotel **Wednesday, April 3, 1974**

Williford Room, Parlor B

"Promise Or Performance"

8-9 A.M.	Coffee and Rolls
9 A.M.	Moderator—Mrs. June Hall, CMA, AAMA Speaker of the House Welcome—Mrs. Norma Domanic, President AAMA, Illinois Society
9:15 A.M.	*Balancing Act* Miss Ruth French, Assistant Dean School of Medical Technology, University of Illinois Medical Center Campus
10 A.M.	*Patients Relations* Arthur R. Fisher, M.D., Chairman Grievance Committee, CMS
11 A.M.	*Managing The Telephone in the Doctor's Office* Mr. Gerald Farley, Assistant Program Director, Division of Medical Practice, AMA (Film features members of the AAMA, ILLINOIS SOCIETY)
12:30 P.M.	Luncheon CONTINENTAL ROOM Moderator—Mrs. Luella Mitchell, AAMA Trustee
1:30 P.M.	*Pediatric Plumbing* Malachi John Flanagan, M.D., Urologist— St. Luke-Presbyterian Hospital
2:30 P.M.	*Credit and Collections* Mr. Maynard Heacox, Program Director, Division of Medical Practice, AMA
3:30 P.M.	*Office Safety* Mrs. Elvera Fischer, RN, CMA, Past President AAMA

REGISTRATION FORM "Promise or Performance" Illinois Society Seminar
April 3, 1974, Fee: $8.50

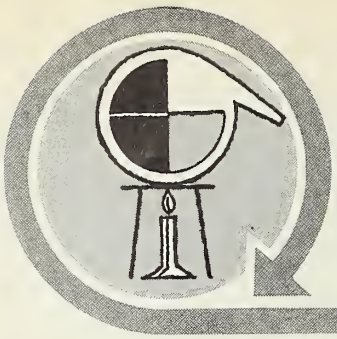
NAME_____ **ADDRESS**_____ **ZIP**_____

CHAPTER_____ **MEMBER** _____ **NON-MEMBER** _____ **OFFICER**_____

EMPLOYER'S NAME_____ **ADDRESS**_____

Make check payable to AAMA, ILLINOIS SOCIETY 1974 CLINICAL CONFERENCE
Mail to: Mrs. Janet Binkowski, Luncheon Chairman—428 Adams Street, Dolton, IL 60419
PLEASE NOTE: Luncheon tickets and receipts will NOT be mailed.–They will be given to you when you register Wednesday, April 3, 1974.

DEADLINE FOR RESERVATIONS MARCH 27, 1974



new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

OVRETTE Oral Contraceptive ℞

Manufacturer: Wyeth Laboratories, Inc.
Nonproprietory Name: Norgestrel
Indications: Contraception
Contraindications: Thrombophlebitis, thromboembolic disorders, cerebral apoplexy. Markedly impaired liver function, abnormal genital bleeding; known or suspected carcinoma of the breast; missed abortion.
Warnings and Precautions: Consult package insert
Dosage: Continuous daily dosage of one tablet
Supplied: Tablets, 0.75 mg.

DECADRON-LA Repository Corticosteroid ℞

Manufacturer: Merck Sharp & Dohme
Nonproprietary Name: Dexamethasone Acetate
Indications: Adrenocorticosteroid therapy when long action is required; given intramuscularly or by local injection.
Contraindications: Systemic fungal infections
Warning and Precautions: See package insert
Dosage: Follow package insert
Supplied: Suspension; 5 cc. vial cc/equivalent to 8 mg. dexamethasone.

DUPLICATE SINGLE DRUGS

ALCAINE Ophth. Sol Local Anesthetic ℞

Manufacturer: Alcon Laboratories, Inc.
Nonproprietary Name: Proparacaine HCl
Indications: Rapid and short-acting topical ophthalmic anesthesia
Precautions: Prolonged use not recommended
Administration: Cataract extraction: One drop every 5 to 10 minutes for 5 to 7 doses. Removal of foreign bodies or sutures: 1 to 2 drops shortly before procedure. Tonometry: 1 to 2 drops prior to measurement.
Supplied: Drop-Tainer 15 cc., 0.5%

LUTATE Inj. Progesterone ℞

Manufacturer: Savage Laboratories, Inc.
Nonproprietary Name: Hydroxyprogesterone caproate
Indications: Amenorrhea, abnormal uterine bleeding, production of secretory endometrium & desquamation; test for endogenous estrogen production.
Contraindications: See package insert
Dosage: 375 mg., i.m. for therapy
125 to 250 mg. for testing
Supplied: Vial 5 cc.; 250 mg./cc.

METAPREL Bronchodilator ℞

Manufacturer: Dorsey Laboratories
Nonproprietary Name: Metaproterenol Sulfate
Indications: Bronchial asthma and reversible bronchospasm.
Contraindications: Cardiac arrhythmia with tachycardia.
Precautions: Use with extreme caution with additional sympathomimetic agents.
Dosage: Two to three inhalations every three or four hours. Total daily inhalations not to exceed twelve.
Supplied: Metered dose inhaler 225 mg.

REGONOL Antagonist ℞

Manufacturer: Organon, Inc.
Nonproprietary Name: Pyridostigmine bromide
Indications: Reversal of effect of nondepolarizing muscle relaxants.
Contraindications: Mechanical obstruction of the urinary and intestinal tract, known hypersensitivity to the drug.
Warnings: Refer to package insert
Dosage: Give i.v. together with atropine sulfate according to instructions.
Supplied: Ampules 2 cc.; 5 mg./cc.

SULFALAR Sulfonamide ℞

Manufacturer: Parke, Davis & Company
Nonproprietary Name: Sulfisoxazole
Indications: Infections due to susceptible organisms
Precautions: Those usual with sulfonamides
Dosage: Adults: initial 2 to 4 gm.; maintenance 2 to 4 gm./24 hrs. Children and infants over 2 months old: initial ½ of the 24 hour dose; maintenance 150 mg./kg./24 hrs. Follow package instructions.
Supplied: Tablets 500 mg.

COMBINATION PRODUCTS

PROPOXYPHENE HCl COMPOUND 65 Analgesic ℞

Manufacturer: Philips Roxane Laboratories, Inc.
Composition:

Propoxyphene HCl	65 mg.
Aspirin	227 mg.
Phenacetin	162 mg.
Caffein	32.4 mg.

Indications: Relief of mild to moderate pain
Contraindications: Do not use in children, use with circumspection in pregnancy.
Precautions: Tolerance has been reported in some patients.

(Continued on page 281)

CONVENTION '74

UNIVERSITY OF ILLINOIS
BINDERY

INDEX

HOUSE OF DELEGATES

Agenda 203
Board of Trustees 195
Committees 205
Delegates and Alternates 196
Ex-Officio Members 195
Officers 195

OFFICERS AND ADMINISTRATION

President 207
President-Elect 208
First Vice-President 208
Second Vice-President 208
Trustee Reports
- First District 209
- Second District 209
- Third District 209
- Fourth District 209
- Fifth District 210
- Sixth District 210
- Seventh District 210
- Eighth District 210
- Ninth District 210
- Tenth District 211
- Eleventh District 211
- Trustee-at-Large 212

Chairman of the Board 212
Speaker of the House of Delegates 213
Vice-Speaker 213
AMA Delegation 213
Committees of the Board of Trustees
- Advisory Committee to the Woman's Auxiliary 215
- Committee on Constitution and Bylaws 215
- Committee on Committees 215
- Ethical Relations Committee 215
- Governmental Health Program Reimbursement 215
- Policy Committee 216
- Publications Committee 216
 - Editor *Illinois Medical Journal* 217

Direct Reporting Committees
- Drugs and Therapeutics 218
- Health Care Financing 219
- Insurance Committee 218
- Physician Competence 219
- Redistricting and Tenure 219

ANCILLARY ORGANIZATIONS

Illinois Council on Continuing Medical Education 220
President of the Woman's Auxiliary 221
Illinois Society, American Association of Medical Assistants 222
Educational and Scientific Foundation 223
Student Loan Fund Board 222

AFFILIATE SOCIETIES

Council on Affiliate Societies 224

ECONOMICS AND PEER REVIEW

Council on Economics and Peer Review 225

EDUCATION AND MANPOWER

Council on Education and Manpower 227
Advisory Committee to Physicians in Training 227

ENVIRONMENTAL AND COMMUNITY HEALTH

Council on Environmental and Community Health 231
Maternal Welfare Committee 231

FINANCES AND BUDGETS

Secretary-Treasurer 235

GOVERNMENTAL AFFAIRS

Governmental Affairs Council 239
Public Affairs Committee 241

MEDICAL-LEGAL

Medical-Legal Council 243
Laboratory Services 244

MENTAL HEALTH AND ADDICTION

Council on Mental Health and Addiction 245

PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Council on Public Relations and Membership Services 250
Fifty-Year Club 251
Placement Service 251

SOCIAL AND MEDICAL SERVICES

Council on Social and Medical Services 252

SPECIAL REPORTS

County Medical Society Officers 198
Illinois Department of Children and Family Services 233
Illinois Department of Mental Health 246
Illinois Department of Public Aid 226
Illinois Department of Public Health 232
Illinois Department of Registration & Education 228
Illinois Division of Vocational Rehabilitation 253
Resolutions 254

Members of the 1974 House of Delegates

OFFICERS

President Willard C. Scrivner
President Elect Fredric D. Lake
Secretary-Treasurer Jacob E. Reisch
Speaker of the House Andrew J. Brislen

TRUSTEES

First District	Joseph L. Bordenave	1974	Fourth District	Fred Z. White	1976
Second District	Allan L. Goslin	1974	Fifth District	A. Edward Livingston	1976
Third District	Wm. M. Lees	1974	Sixth District	Mather Pfeiffenberger	1975
	Eugene T. Hoban	1975	Seventh District	Arthur F. Goodyear	1976
	Warren W. Young	1975			
	Joseph Skom	1975	Eighth District	Eugene P. Johnson	1976
	Robert T. Fox	1976	Ninth District	Warren D. Tuttle	1975
	David S. Fox	1976	Tenth District	Herbert Dexheimer	1975
	Frederick E. Weiss	1976	Eleventh District	Joseph R. O'Donnell	1974
	George Shropshear	1974			
	Philip G. Thomsen	1974	Trustee-at-Large	Frank J. Jirka, Jr.	

EX OFFICIO

(Privilege of the floor but without the right to vote)
1st Vice President Paul W. Sunderland
2nd Vice President Charles J. Weigel
Vice Speaker (when not presiding) James McDonald

Past Presidents

J. Ernest Breed	1971	Willis I. Lewis	1954
Edward W. Cannady	1970	George F. Lull	1963
Everett P. Coleman	1945-46	Burtis E. Montgomery	1966
Newton DuPuy	1968	Edward A. Piszczek	1965
Harlan English	1964	Caesar Portes	1967
Edwin S. Hamilton	1962	Leo P. A. Sweeney	1953
H. Close Hesseltine	1961	Philip G. Thomsen	1969
C. J. Jannings, III	1972	Arkell M. Vaughn	1955
Frank J. Jirka, Jr.	1973		

Delegates to AMA

Carl E. Clark	Maurice M. Hoeltgen	Edward A. Piszczek
Jack L. Gibbs	Frank J. Jirka, Jr.	Philip G. Thomsen
Theodore Grevas	William M. Lees	Theodore R. Van Dellen
H. Close Hesseltine	Morgan M. Meyer	Charles K. Wells

Past Trustees or Councilors

William E. Adams	Third District	Fredric D. Lake	Third District
Earl H. Blair	Third District	Ted LeBoy	Third District
Walter C. Bornemeier	Third District	William A. McNichols, Jr.	Second District
Carl E. Clark	First District	Warner H. Newcomb	Sixth District
Newton DuPuy	Sixth District	Ralph N. Redmond	Second District
Willard W. Fullerton	Tenth District	Wm. H. Schowengerdt	Eighth District
George E. Giffin	Second District	Darrell H. Trumpe	Fifth District
Lee N. Hamm	Fifth District	Charles K. Wells	Ninth District
George A. Hellmuth	Third District	Paul P. Youngberg	Fourth District
Bernard Klein	Eleventh District		

Delegates and Alternate Delegates to the Illinois State Medical Society

DOWNSTATE DELEGATES

County	*Delegates*	*Alternate*
Adams	James Sutherland	Newton DuPuy
Alexander	Charles Yarborough	Gemo Wong
Bond	M. K. Kaufman	Boyd McCracken
Boone	John Steinkamp	Wesley B. Oliver
Bureau	P. L. Lymberopoulos	L. P. LuKancic
Carroll	L. B. Hussey	T. Maciejczyk
Cass-Brown	B. A. DeSulis	J. J. Hea
Champaign (2)	James M. Laidlaw	Benjamin Robbins
	C. H. Walton	Homer Hindman
Christian	R. M. Seaton	F. W. Siegert
Clark	George Mitchell	James R. Buechler
Clay	D. L. Bunnell	*None*
Clinton	B. E. Floreza	W. L. DuComb
Coles-Cumberland	M. W. Hollowell	Joseph R. Mallory
Crawford	C. M. Maples	Dean Pelley
DeKalb	John Ovitz	D. J. Ladd
DeWitt	Charles A. Ramey	Herman Meltzer
Douglas	Walter G. Steiner	Humberto Mondul
DuPage (6)	Morgan M. Meyer	John V. Ryan
	J. P. Campbell	Robert Fitzgerald
	Kenneth Hurst	Oren D. Baab
	Robert Dooley	Charles H. Westfall
	Wm. C. Perkins	Jack S. Burton
	Wm. B. Frymark	Dan Butcher
Edgar	J. M. Ingalls	Charles Salesman
Edwards	Andrew Krajec	Paul S. Neirenbérg
Effingham	Hector Morales	P. C. Rumore
Fayette	S. W. Moore	D. H. Rames
Ford	Ross H. Hutchison	Edson L. Etherton
Franklin	John P. Pope	James P. Durham
Fulton	J. L. Gibbs	J. K. Welch
Gallatin	John E. Doyle	None
Greene	James C. Reid	Jude A. Caselton
Hancock	Charles Eddingfield	James Coeur
Henderson	Silvino C. Lindo, Jr.	J. F. Allman
Henry-Stark	James C. Parsons	William D. Larson
Iroquois	R. K. Swedlund	James Dailey
Jackson (2)	Paul Lorenz	Eli Borkon
Jasper	*Not Sending Delegates*	
Jefferson-Hamilton	Antonio Baba	James Heersma
Jersey-Calhoun	Bernard Baalman	Larry Plummer
Jo Daviess	William Gillies	Francis B. Waites
Kane (4)	A. B. Johnson	Wm. T. Sheehy
	George J. Shimkus	A. Gail Baxter
	Gerald J. Liesen	Peter J. Starrett
	Wayne N. Leimbach	Joseph Young
Kankakee	James Geist	Donald Parkhurst
Kendall	Walter H. Brill	Joseph L. Daw
Knox	John J. Holland	H. L. Fleisher, Jr.
Lake (4)	John J. Ring	Manoochehr Sharifi
	David Helberg	Richard Hawkins
	Herman Lustigman	Richard Dolan
	Eugene Pitts	John Andrews
LaSalle	E. J. Fesco	Richard Schmidt
Lawrence	Gilbert Miller	R. C. Kirkwood
Lee	Donald Edwards	
Livingston	Karl Deterding	Thomas Minogue
Logan	Glen E. Tomlinson	James Borgerson
Macon (2)	A. J. Kiessel	R. D. Miller
	C. L. Sandburg	M. J. Schrodt
Macoupin	Lee L. Johnson	Nicolas C. Pineda
Madison (2)	Edward DuVivier	E. F. Ragsdale
	George T. Wilkins	Robert Hill
Marion	W. W. Davidson	Walter P. Plassman
Mason	Jack Means	Dario Landazuri
Massac	*Not Sending Delegates*	
McDonough	D. I. Mazor	S. M. Gines
McHenry	George Alvary	
McLean	Loren Boon	Robert Reardon
Menard	Robert Schafer	Paul L. Purdy
Mercer	R. N. Svenson	Monty P. McClellan
Monroe	Joseph A. Werth	E. F. Maglosang
Montgomery	James T. Foster	Roger McFarlin
Morgan-Scott	Robert R. Hartman	E. C. Bone
Moultrie	Dean E. McLaughlin	E. J. Boris
Ogle	Robert F. Dearborn	Don Hinderliter
Peoria (3)	G. W. Giebelhausen	Fred J. Heinzen
	Henry A. Boldt	Carl F. Neuhoff
	Hugh J. McMenamin	John W. Berney
Perry	C. E. Cawvey	James Stotlar
Piatt	George G. Green	Marion D. Kinzie
Pike	Meyer Shulman	Gene Goodman
Pulaski	*To be elected*	*To be elected*
Randolph	O. W. Pflasterer	J. M. Whittenberg
Richland	C. A. DeKovessey	John S. Dunker
Rock Island (2)	Theodore Grevas	Richard Phillis
	Wm. Dogherty	Richard A. Arnell
St. Clair (3)	Julian W. Buser	Charles R. Frazer
	John S. Hipskind	Donald Jerome
	H. Frank Holman	Thomas P. Meirink
Saline-Pope Hardin	Earl E. Walker	Elliott O. Partridge
Sangamon (3)	Patrick Mahon	Robert P. Johnson
	Earl D. Donelan	Ross Schlich
	Edward G. Ference	Stuart A. Yaffe
Schuyler	Henry C. Zingher	Robert E. Cox
Shelby	Duncan Biddlecomb	Richard Larson
Stephenson	E. L. Vickery	James Berry
Tazewell	Daniel E. Baer	Albert Martens
Union	Robert Rader	William Whiting
Vermilion	A. M. Taylor	J. L. Gulick
Wabash	Donald Risley	Charles Salisbury
Warren	Russell Jensen	Kenneth Ambrose
Washington	Jerry L. Beguelin	Charles Longwell
Wayne	C. J. Jannings	Edward Talaga
White	William Courtnage	Philip Boren
Whiteside	John F. Hubbard	Claude Mueller
Will-Grundy (3)	Robert J. Becker	Robert Kramer
	Guy A. Pandola	Raymond R. Clemens
	Barry S. Seng	Michael Greenwald
Williamson	Herbert V. Fine	Roger Hendricks
Winnebago (4)	P. John Seward	Alexander Halle
	E. T. Leonard	D. P. Feeney
	F. H. Riordan	Donald Wrork
	Robert A. Behmer	Nelson Gurney
Woodford	Robert P. Lykkebak	Tom Barrett
Student Amer. Medical Association	Jeff Waitzman	William Yasnoff

CHICAGO MEDICAL SOCIETY

Delegates	*Alternate Delegates*
Aux Plaines Branch	
John S. Hyde	Allison L. Burdick, Jr.
Chester B. Thrift	Robert C. Muehrcke
William Ashley	Meredith B. Murray
C. Otis Smith	Martin W. Green
Joseph B. Moles	Arthur G. Lawrence
Roland Kowal	Gustav A. Hemwall
Allison L. Burdick, Sr.	Richard H. Blankshain
Everett E. Nicholas	Arthur R. Fischer
John W. Tope	Harold M. Kass
Calumet Branch	
Luther M. Lorance	Joseph Koczura
Herman Reyes	John Juhasz
Douglas Park Branch	
Edward A. Razim	Frank Jirka, Jr.
Coleman J. O'Neill	Robert F. Cesafsky
Loren B. Horton	Gerald Neskodney
Charles Mrazek	Eldis M. Christensen
Raymond Nemecek	Miles Cermak
Englewood Branch	
Edward Krol	John Krolikowski
Frank Kwinn	Martin Shobris
Frank J. Saletta	Stanley Budrys
William Nainis	John Meyer
North Suburban Branch	
Leon L. Ampel	Harley Sigmond
Richard Stalzer	Carl Johner
To be elected	Myles P. Cunningham
William J. FitzPatrick	Jerome T. Paul
John W. O'Donnell	George A. McDermott
Howard C. Burkhead	Daniel J. Murphy
David W. Cromer	Thomas G. Soper
C. Malcolm Rice, Jr.	John M. Bailey
John L. Savage	Thomas Stafford
James W. Ford	James R. Dillon
Irving Park Suburban Branch	
Herman Wing	Theodore Johnson
Fred Tworoger	Sanford Franzblau
Lawrence Hirsch	Thomas Conley
Martin P. Meisenheimer	George W. Holmes
Allen Hrejsa	Alexander Ruggie
George C. Turner	A. Clementi
Vincent C. Sarley	Philip H. Heller
Alfred J. Faber	Peter Pleotis
Earl U. Solon	Raymond S. Rowlette
George Lagorio	Eugene Broccolo
Jackson Park Branch	
Julius E. Ginsberg	William P. Mavrelis
Loran H. Dill	Lester O'Dell
Murray M. Paull	Myron M. Hirskind
Mathew W. Kobak	Nerissa Singh
Henrietta Herbolsheimer	Helen Cook Newman

Delegates	*Alternate Delegates*
North Shore Branch	
Philip R. McGuire	H. Kenneth Scatliff
Herschel Browns	Samuel T. Gerber
George C. Markoutsas	Lief Bjornssen
Joseph R. DeCaro	William B. Stromberg, Jr.
William O. Ackley	Frank Hussey
John B. Murphy	Jack D. Clemis
David T. Petty	Steven J. Spinuzza
Norman M. C. Olsen	Danford Chamberlain
Burton J. Soboroff	Joseph H. Skom
Clarence A. Norberg	Rocco V. Lobraico
North Side Branch	
Vincent C. Freda	Richard Perritt
Jack Williams	Benjamin F. Lounsbury
Erwin M. Patlak	I. Pat Bronstein
Clifton L. Reeder	Joseph Schifano
James P. FitzGibbons	Randolph W. Seed
Joseph C. Sherrick	Peter Wolkonsky
Roland R. Cross	Daniel Ruge
Samuel L. Andelman	George S. Farah
William A. Hutchison	Bernard T. Peele
C. Larkin Flanagan	Ray Silins
Northwest Branch	
Alfred A. Zanette	I. P. Lombardo
Michael A. Rydelski	Alfonso Diaz
E. J. Kotanyi	N. J. Kupferberg
Gonzalo Ruiz	John Szewczyk
South Chicago Branch	
Arne E. Schairer	Jere Freidheim
Morris T. Friedell	Maynard I. Shapiro
Anthony G. Cesare	Vincent Costanzo
South Side Branch	
Kermit T. Mehlinger	Vernon R. DeYoung
Alfred Klinger	Jacob M. Epstein
Robert R. Mustell	Aldo Pedroso
Otto J. Keller	*To be elected*
Southern Cook County Branch	
Harold L. Jensen	William E. Ricketts
Peter I. Fagen	Abraham Gelperin
Aaron B. Gerber	Joseph Gorecki
Conrad J. Urban	Romin I. Filipowicz
Stock Yards Branch	
Edwin J. Lukaszewski	Frank J. Nowak
West Side Branch	
William J. Tansey	Jacob Ungar
Anna Marcus	Henry B. Okner
J. Robert Thompson	Louis S. Varzino

At-Large

Howard C. Burkhead
Charles P. McCartney
A. Everett Joslyn
Alfred J. Faber

Officers of County Medical Societies

1974

County	President	Secretary
Adams Members: 85-Dist. No. 6	George H. Eversman 1415 Vermont, Quincy 62301	Julio del Castillo Ill. St. Bank Bldg., Quincy 62301
Alexander Members: 6-Dist. No. 10	Gemo Wong 1201 Washington, Cairo 62914	Charles L. Yarbrough 800 Commercial, Cairo 62914
Bond Members: 8-Dist. No. 7	James R. Goggin 207 N. 2nd St., Greenville 62246	Kenneth Kaufman 105 E. College, Greenville 62246
Boone Members: 14-Dist. No. 1	M. Joseph Carlisle 115 W. Lincoln, Belvidere 61108	Earl S. Davis 119 S. State, Belvidere 61108
Bureau Members: 23-Dist. No. 2	Kent McQueen Tiskilwa 61368	Karl D. Nelson 101 Park, Princeton 61356
Carroll Members: 8-Dist. No. 1	C. G. Piper 203 W. Market, Mt. Carroll 61053	Eliseo M. Colli 102 Washington, Mt. Carroll 61053
Cass-Brown Members: 6-Dist. No. 6	R. A. Spencer 115 W. 4th St., Beardstown 62618	A. G. Hyde 507 Washington, Beardstown 62618
Champaign Members: 205-Dist. No. 8	Stanley Smith Carle Clinic, Urbana 61801	H. Ewing Wachter 1609 W. Springfield, Champaign 61820
Christian Members: 20-Dist. No. 7	R. M. Seaton Morrisonville 62546	J. W. Murphy 301 S. Webster, Taylorville 62568
Clark Members: 5-Dist. No. 8	Eugene P. Johnson P.O. Box 68, Casey 62420	Charles G. Moore, Jr. Martinsville Clinic, Martinsville 62442
Clay Members: 7-Dist. No. 7	A. Paul Naney Flora Clinic, Flora 62839	Donald L. Bunnell Flora Clinic, Flora 62839
Clinton Members: 12-Dist. No. 7	M. B. Floreza 118 North Oak, Trenton 62293	F. H. Ketterer 289 N. Main St., Breese 62230
Coles-Cumberland Members: 39-Dist. No. 8	Ray A. Dougherty Link Clinic, Mattoon 61938	Jerry D. Heath 6 Orchard Drive, Charleston 61920
Crawford Members: 14-Dist. No. 8	Herbert F. Iknayan 408 So. Cross, Robinson 62454	W. B. Schmidt 408 So. Cross, Robinson 62454
De Kalb Members: 52-Dist. No. 1	H. Logan Fisher 1838 Sycamore Rd., DeKalb 60115	William Deschler 225 Edwards, Sycamore 60178
De Witt Members: 9-Dist. No. 5	John W. Viers 219 E. Main, Clinton 61727	Charles A. Ramey 215 E. Main, Clinton 61727
Douglas Members: 9-Dist. No. 8	Humberto Mondul 100 N. Main, Tuscola 61953	Elmer S. Allen 120 S. Locust, Arcola 61910
Du Page Members: 440-Dist. No. 11 Lillian Widmer, Exec. Sec. 646 Roosevelt Rd. Glen Ellyn 60137	Robert D. Dooley 5101 Willow Springs Rd. LaGrange 60525	James P. Campbell 322 N. Blanchard, Wheaton 60187
Edgar Members: 16-Dist. No. 8	Joseph R. Shackelford Medical Center Clinic, Paris 61944	J. M. Ingalls 502 Shaw, Paris 61944
Edwards Members: 2-Dist. No. 9	Paul S. Neirenberg 7 W. Main, Albion 62806	Andrew Krajec Box 336, West Salem 62476
Effingham Members: 20-Dist. No. 7	Frederick M. Reis 503 N. Maple, Effingham 62401	H. E. Morales 300 N. Maple, Effingham 62401

County	President	Secretary
Fayette Members: 9-Dist. No. 7	D. H. Rames Vandalia 62471	E. A. Kuehn 501 W. Gallatin, Vandalia 62471
Ford Members: 10-Dist. No. 11	William A. Garrett Sibley 61773	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
Franklin Members: 21-Dist. No. 9	Loren L. Love 6 Hillcrest Dr., Christopher 62822	D. P. Richerson P.O. Box 99, Christopher 62822
Fulton Members: 26-Dist. No. 4	Robert W. Ridley Coleman Clinic, Canton 61520	Marvin E. Schmidt Graham Hospital, Canton 61520
Gallatin Members: 2-Dist. No. 9	Wilbur Stanelle Shawneetown 62984	John E. Doyle Ridgway 62979
Greene Members: 6-Dist. No. 6	Gary L. Turpin 712 S. College, Greenfield 62044	James C. Reid Fillager Mem. Clinic, Greenfield 62044
Hancock Members: 10-Dist. No. 4	Werner Schoenherr Bowen, Ill. 62316	James E. Coeur 630 Locust, Carthage 62321
Henderson Members: 1-Dist. No. 4		Silvino Lindo, Jr. Biggsville 61448
Henry-Stark Members: 29-Dist. No. 4	Luis J. Garcia 719 Elliott St., Kewanee 61443	David E. Stearns 716 Elliott St., Kewanee 61443
Iroquois Members: 17-Dist. No. 11	D. R. Cozad Clifton 60927	Dale Learned 219 N. Central, Gilman 60938
Jackson Members: 50-Dist. No. 10	Allan Bennett P.O. Box 2347, Carbondale 62901	Paul Lorenz P.O. Box 2347, Carbondale 62901
Jasper Members: 2-Dist. No. 8	Don L. Hartrich Box 192, Newton 62448	Monico Low P.O. Box 188, Newton 62448
Jefferson-Hamilton Members: 36-Dist. No. 9	Kelly M. Berkley Doctors Park Rd., Mt. Vernon 62864	Antonio Boba #1 Doctors Pk. Rd., Mt. Vernon 62864
Jersey-Calhoun Members: 10-Dist. No. 6	Bernard Baalman Medical Center, Hardin 62047	Larry Plummer 306 S. Washington, Jerseyville 62052
Jo Daviess Members: 9-Dist. No. 1	Wilbur E. Johnson Galena 61036	Lyle A. Rachuy 323 N. Main St., Stockton 61085
Johnson Members: 1-Dist. No. 9		
Kane Members: 273-Dist. No. 1 Michael Wild, Exec. Dir. 214 W. State St. Geneva 60134	James E. Habegger 32 So. Lincoln, Geneva 60134	James C. Pritchard 1725 So. St., Geneva 60134
Kankakee Members: 92-Dist. No. 11	Preston W. Sawyer Meadowview Center, Kankakee 60901	A. A. Palow 555 So. Schuyler, Kankakee 60901
Kendall Members: 8-Dist. No. 11	Joseph L. Daw Oswego Medical Group, Oswego 60543	Suzanne M. Roscoe Oswego Medical Group, Oswego 60543
Knox Members: 59-Dist. No. 4	Kent Kleinkauf 632 Bondi Bldg., Galesburg 61401	Juan Espejo 695 N. Kellogg, Galesburg 61401
Lake Members: 266-Dist. No. 1 Mrs. Julia Schulz Exec. Sec., P.O. Box 148 Gurnee 60031	Lionel W. Ganshirt 1140 Ash Lawn Dr., Lake Forest 60045	George A. Olander 1950 Sheridan Rd. Highland Park 60035
La Salle Members: 91-Dist. No. 2	Robert Lewis 628 Columbus, Ottawa 61350	Allan L. Goslin 712 N. Bloomington, Streator 61364

County	President	Secretary
Lawrence Members: 8-Dist. No. 8 Ruth Gariepy, Exec. Sec. Lawrence City Mem. Hosp. Lawrenceville 62439	R. T. Kirkwood Kensler Bldg., Lawrenceville 62439	Larry D. Herron N. Main St., Bridgeport 62417
Lee Members: 22-Dist. No. 2	Wayne Spenader Amboy 61310	William McNichols 101 W. 1st St., Dixon 61021
Livingston Members: 31-Dist. No. 2	Thomas Minoque Fairbury Medical Assoc. Fairbury 61739	Karl T. Deterding 612 E. Water St., Pontiac 61764
Logan Members: 21-Dist. No. 5	H. R. Rivero 914 E. Broadway, Lincoln 62656	Toby E. Silverstein 311 8th St., Lincoln 62656
Macon Members: 141-Dist. No. 7 Mary J. Bretz, Exec. Sec. 1800 E. Lake Shore Dr. Decatur 62521	A. J. Kiessel 1800 E. Lake Shore, Decatur 62521	William C. Simon 1807 N. Edward St., Decatur 62521
Macoupin Members: 19-Dist. No. 6	William W. Lusk 224 E. Main St., Carlinville 62626	Lee Johnson 426 W. Pearl St., Staunton 62088
Madison Members: 130-Dist. No. 6	Alan Skirball 2044 Madison Ave., Granite City 62040	Norman E. Taylor 95 So. 9th St., E. Alton 62024
Marion Members: 37-Dist. No. 7	Percy C. May 502 N. Elm St., Centralia 62801	Walter P. Plassman Box 552, Centralia 62801
Mason Members: 6-Dist. No. 5	Dario Landasuri 125 N. Orange St., Havana 62644	Henry W. Maxfield Mason City 62664
Massac Members: 4-Dist. No. 9	James L. Bremer 805 Market St., Metropolis 62960	Ralph K. Frazier Hospital Dr., Metropolis 62960
McDonough Members: 26-Dist. No. 4	Joseph L. Symmonds 301 E. Jefferson St., Macomb 61455	Stephan L. Roth Box 258, Colchester 62326
McHenry Members: 63-Dist. No. 1 Evelyn Rosulek, Exec. Sec. 308 E. Kimball Woodstock 60098	Vincenzo B. Petralia 445 Park Ave., Cary 60013	Aniceto M. D'Sousa 1110 N. Green St., McHenry 60050
McLean Members: 89-Dist. No. 5	George Shonat 401 W. Virginia, Normal 61761	Douglas R. Bey 401 W. Virginia, Normal 61761
Menard Members: 2-Dist. No. 5	Robert J. Schafer 116 N. 5th, Petersburg 62675	Robert J. Schafer 116 N. 5th St., Petersburg 62675
Mercer Members: 5-Dist. No. 4	R. N. Svendsen 209 S. College, Aledo 61231	Monty P. McClellan 309 NW 2nd St., Aledo 61231
Monroe Members: 9-Dist. No. 10	Joseph A. Werth Waterloo 62298	Edelberto Maglasang 109 W. Legion, Columbia 62236
Montgomery Members: 15-Dist. No. 5	Roger C. McFarlin 400 Rountree, Hillsboro 62049	James T. Foster 8 Arrowhead Rd., Litchfield 62056
Morgan-Scott Members: 41-Dist. No. 6	Richmond H. Simmons 1515 W. Walnut, Jacksonville 62650	Robert H. Kooiker 801 Lincoln, Jacksonville 62650
Moultrie Members: 5-Dist. No. 7	Eugene Boros Bethany 61914	H. E. Kendall 112 E. Harrison, Sullivan 61951
Ogle Members: 19-Dist. No. 1	Thomas L. Koritz 324 Lincoln Hgwy., Rochelle 61068	Russell Zack 515 Lincoln Hgwy., Rochelle 61068
Peoria Members: 255-Dist. No. 4 David W. Meister, Jr. Exec. Sec. 427 1st Nat. Bk. Bldg. Peoria 61602	Willard M. Easton 427 1st Nat. Bk. Bldg., Peoria 61602	Gene O. Hoerr 427 1st Nat. Bk. Bldg., Peoria 61602

County	President	Secretary
Perry Members: 15-Dist. No. 10	Clarence E. Cawvey 20 N. Main, Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
Piatt Members: 6-Dist. No. 7	George Green 121 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
Pike Members: 9-Dist. No. 6	Warren C. Barrow 321 W. Washington, Pittsfield 62363	B. J. Rodriguez 868 Mortimer, Barry 62312
Pulaski Members: 1-Dist. No. 10	A. L. Robinson Box 277, Mounds 62964	
Randolph Members: 15-Dist. No. 10	V. S. Katty 312 E. Broadway, Steeleville 62288	C. S. Schlageter 101 N. Market, Sparta 62286
Richland Members: 21-Dist. No. 8	Willard J. Eyer 119 Market St., Olney 62450	David R. Benson 1200 N. East St., Olney 62450
Rock Island Members: 152-Dist. No. 4 James A. Koch, Exec. Sec. 612 Kahl Bldg. Davenport, Iowa 52801	N. T. Braatelein 635 10th Ave., Moline 61265	J. P. Johnston 1630 5th Ave., Moline 61265
St. Clair Members: 207-Dist. No. 10 Ed Belz, Exec. Dir. 4825 W. Main St. Belleville 62223	Theodore L. Bryan 3120 State St. East St. Louis 62205	Clarence J. Oerter 1915 W. Main, Belleville 62221
Saline-Pope-Hardin Members: 24-Dist. No. 9	Grover G. Sloan Carrier Mills 62917	Warren R. Dammers P.O. Box 281, Harrisburg 62946
Sangamon Members: 227-Dist. No. 5 L. R. Brosi, Exec. Sec. 2100 Lindsay Rd. Springfield 62704	Donald H. Yurdin 1000 So. Sixth St., Springfield 62702	Robert L. Prentice 701 N. Walnut, Springfield 62702
Schuyler Members: 3-Dist. No. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
Shelby Members: 8-Dist. No. 7	Duncan Biddlecombe 805 W.N. 6th, Shelbyville 62565	Smith D. Taylor Box 355, Shelbyville 62565
Stephenson Members: 48-Dist. No. 1	Erich Awender 1717 W. Church, Freeport 61032	Roger Jinkins Freeport Mem. Hosp., Freeport 61032
Tazewell Members: 45-Dist. No. 5 David W. Meister, Jr. Exec. Sec. 427 1st Nat. Bk. Bldg. Peoria 61602	Theofan R. Trifonoff 427 1st Nat. Bk. Bldg., Peoria 61602	Robert M. Wright 427 1st Nat. Bk. Bldg., Peoria 61602
Union Members: 6-Dist. No. 10	Robert L. Rader 200 N. Main St., Anna 62906	William H. Whiting Box 410, Anna 62906
Vermilion Members: 81-Dist. No. 8	Grover L. Seitzinger 812 N. Logan, Danville 61832	L. W. Tanner 7 N. Virginia, Danville 61832
Wabash Members: 7-Dist. No. 9	Ernest Lowenstein 1128 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863
Warren Members: 10-Dist. No. 4	W. Roller 309 So. Main, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
Washington Members: 2-Dist. No. 10	Charles Longwell Nashville 62263	Jerry L. Beguelin Irvington Med. Ct., Irvington 62848
Wayne Members: 6-Dist. No. 9	Edward S. Talaga 101 E. Center St., Fairfield 62837	Arthur Marks 408 W. Center St., Fairfield 62837
White Members: 8-Dist. No. 9	William Courtnage West Main St., Carmi 62821	Morris McCall So. Plum St., Carmi 62821

County	President	Secretary
Whiteside Members: 37-Dist. No. 2	Howard Christofersen 101 E. Miller, Sterling 61081	James McGee 1716 Locust St., Sterling 61081
Will-Grundy Members: 198-Dist. No. 11 Don M. Kline, Exec. Sec. 58 N. Chicago, Rm. 201 Joliet 60431	Thomas J. Fitzpatrick 58 N. Chicago, Joliet 60431	Antanas Razma 58 N. Chicago, Joliet 60431
Williamson Members: 28-Dist. No. 9	Robert D. Kane 120 W. Walnut, Herrin 62948	Herbert V. Fine 110 N. Division, Carterville 62918
Winnebago Members: 301-Dist. No. 1 Mrs. Johanna Lund Exec. Adm., 310 N. Wyman Rockford 61101	James H. Topp 310 N. Wyman, Rockford 61101	John English 310 N. Wyman, Rockford 61101
Woodford Members: 8-Dist. No. 2	K. Vaicius Minonk 61760	James W. Riley 109 S. Major St., Eureka 61530

No Organized County Society

Johnson
Marshall
Putnam

Joint County Societies

Cass-Brown
Coles-Cumberland
Henry-Stark
Jefferson-Hamilton
Jersey-Calhoun
Morgan-Scott
Saline-Pope-Hardin
Will-Grundy

Chicago Medical Society

President: Charles P. McCartney
P.O. Box 581, Palos Heights 60463
Secretary: Henrietta Herbolsheimer
5528 S. Hyde Park Blvd., Chicago 60637
Executive Administrator: Robert J. Lindley
310 S. Michigan Ave., Chicago 60604
Members: 7,110 (including Residents) District No. 3

Branch Officers

AUX PLAINES BRANCH
President: John W. Tope
163 N. Euclid, Oak Park 60302
Secretary: Meredith B. Murray
414 S. Oak Park Ave., Oak Park 60302

CALUMET BRANCH
President: Robert E. Lee
9948 S. Western Ave., Chicago 60643
Secretary-Treasurer: Edwin L. Fallon
6450 S. Francisco Ave., Evergreen Park 60642

DOUGLAS PARK BRANCH
President: Loren B. Horton
7 S. Waiola Ave., La Grange 60525
Secretary: Fabian O. Ostrowski
3601 S. Austin Blvd., Cicero 60650

ENGLEWOOD BRANCH
President: Stanley Budrys
2751 W. 51st St., Chicago 60632
Secretary-Treasurer: William F. DeRose
3729 W. 96th St., Evergreen Park 60642

NORTH SUBURBAN BRANCH
President: Daniel J. Murphy
2510 Ridgeway, Evanston 60201
Secretary-Treasurer: James W. Ford
636 Church St., Evanston 60201

IRVING PARK SUBURBAN BRANCH
President: Herman Wing
400 E. Randolph St., Chicago 60601
Secretary: George Lagorio
1625 Forest Dr., Glenview 60025

JACKSON PARK BRANCH
President: Thomas W. Lester
2017 W. 107th St., Chicago 60543
Secretary-Treasurer: Ralph F. Naunton
6837 S. Euclid Ave., Chicago 60649

NORTH SHORE BRANCH
President: Arthur P. Peterson
2760 W. Foster, Chicago 60625
Secretary: Samuel Nieder
4033 N. Damen Ave., Chicago 60640

NORTH SIDE BRANCH
President: Carl F. Palumbo
1519 N. Franklin Ave., River Forest 60305
Secretary-Treasurer: Joseph C. Sherrick
303 E. Superior St., Chicago 60611

NORTHWEST BRANCH
President: Alfonso Diaz
1802 S. Racine Ave., Chicago 60608
Secretary-Treasurer: Theodore R. Tenczar
6324 N. Milwaukee Ave., Chicago 60646

SOUTH CHICAGO BRANCH
President: Anthony C. Guzauskas
10137 S. Hoyne Ave., Chicago 60643
Secretary-Treasurer: William S. Smith
1100 E. 173rd Pl., South Holland 60473

SOUTH SIDE BRANCH
President: Kermit Mehlinger
4901 Drexel Blvd., Chicago 60615
Secretary: Otto J. Keller
5825 S. Dorchester Ave., Chicago 60637

SOUTHERN COOK COUNTY BRANCH
President: Roman I. Filipowicz
28 E. Robin Lane, South Holland 60473
Secretary-Treasurer: Conrad Urban
2823 W. 173rd St., Hazel Crest 60429

STOCK YARDS BRANCH
President: Maurice M. Hoeltgen
1836 W. 87th St., Chicago 60620
Secretary-Treasurer: Edwin J. Lukaszewski
1213 W. 51st St., Chicago 60609

WEST SIDE BRANCH
President: Eugene T. Hoban
6429 W. North Ave., Oak Park 60302
Secretary-Treasurer: Henry B. Okner
6435 W. North Ave., Oak Park 60302

Agenda

1974 House of Delegates

Andrew J. Brislen, *Speaker*

James A. McDonald, *Vice-Speaker*

FIRST SESSION

3:00 P.M. Wednesday, April 3, 1974

Grand Ballroom

Conrad Hilton Hotel—Chicago

1. Call to Order—*Speaker* Andrew J. Brislen, M.D.
2. Invocation
3. Report of Credentials Committee—Roll Call
4. Report of Committee on Rules and Order of Business
5. Approval of the minutes of the March, 1973, meeting
6. Memorial Service for Deceased members since March, 1973, Conducted by Jacob E. Reisch, M.D., *Secretary-Treasurer*
7. Reports of Special Guests
 A) President, Woman's Auxiliary to ISMS
 B) President, American Association of Medical Assistants, Illinois Society
8. Introduction of Special Guests
 President, AMA Woman's Auxiliary
 Mrs. Willard C. Scrivner
 Officers of other Medical Societies
 by Willard C. Scrivner, M.D., *President*
9. Presentation of AMA-ERF check to representative of Illinois Medical Schools
10. Presentation of Special Awards
 Edwin S. Hamilton Teaching Award
11. The President's Address
 Willard C. Scrivner, M.D.
12. IMPAC Report
 Fred A. Tworoger, M.D., *Chairman*
13. Report of Executive Administrator
 Roger N. White
14. Introduction of AMA Delegates & Alternates
 Carl E. Clark, M.D., *Chairman of Delegation*
15. Remarks of Speaker
 Introduction of New Delegates
16. Reference Committees—announcement of changes
17. Resolutions and Supplementary Reports
 a) Changes of those in handbook
 b) Late resolutions
 (1) Those accepted for introduction
 (2) Those not accepted for introduction
 c) Supplementary report assignment
18. New Business—Announcements
 Delegates Buffet—5:30-6:30 P.M.
 Reference Committees—7:00 P.M.
19. Recess until Friday, April 5, 1974

SECOND SESSION

2:00 P.M. Friday, April 5, 1974

Grand Ballroom

Conrad Hilton Hotel—Chicago

1. Call to Order by the Speaker-Andrew J. Brislin
2. Invocation
3. Roll Call
4. Report—Committee on Rules and Order of Business
5. Announcements
6. Introduction—Guests and Visitors
7. Reports of Reference Committees
 a. Constitution and Bylaws
 James Laidlaw, M.D., *Chairman*
 b. Officers and Administration
 John Ring, M.D., *Chairman*
 c. Finances, Budgets and Publications
 C. Otis Smith, M.D., *Chairman*
 d. Governmental Affairs
 Theodore Grevas, M.D., *Chairman*
 e. Education and Manpower
 Morris K. Friedell, M.D., *Chairman*
 f. Environment, Community, Public and Mental Health
 J. Robert Thompson, M.D., *Chairman*
 g. Economics and Social Services, Peer Review
 John W. Ovitz, M.D., *Chairman*
 h. Public Relations and Miscellaneous Business
 Lawrence Hirsch, M.D., *Chairman*
8. Unfinished Business
9. New Business—Announcements
10. Recess until 9:30 A.M. Saturday, April 6, 1974

THIRD SESSION

9:30 A.M. Saturday, April 6, 1974

Grand Ballroom

Conrad Hilton Hotel—Chicago

1. Call to Order by the Speaker—Andrew J. Brislen
2. Invocation
3. Roll Call—Report of Credentials Committee
4. Report—Committee on Rules and Order of Business
5. Induction of Fredric D. Lake, *President-Elect* into office of President by Willard C. Scrivner
6. Address of President Lake
7. Introduction of guests and visitors
8. Announcements—Presentation of Awards
 Journalism Fellowship
 Scientific Exhibit
9. Reference Committees—Remaining Reports
10. Elections
 Report of Nominating Committee
 a) President-Elect (Downstate)
 b) 1st Vice President (CMS)
 c) 2nd Vice President (Downstate
 d) Secretary-Treasurer (Downstate)
 e) Speaker of House (CMS)
 f) Vice Speaker (Downstate)
 g) Trustees

DISTRICT	Terms Expiring
1st	Joseph L. Bordenave
3rd	William M. Lees
3rd	George Shropshear
3rd	Philip G. Thomsen
11th	Joseph R. O'Donnell

 h) Delegates to AMA to take office Jan. 1, 1975, and serve to Dec. 31, 1976.
 Terms Expiring:
 Carl E. Clark
 H. Close Hesseltine
 Maurice M. Hoeltgen
 William M. Lees
 Theodore R. Van Dellen
 Charles K. Wells
 Alternate delegates to AMA
 Terms Expiring:
 Alfred J. Faber
 Fredric D. Lake
 Eugene T. Leonard
 Joseph R. O'Donnell
 John Ring
 Fred A. Tworoger
11. Fixing of per capita dues for 1975
12. Selection of meeting place and time for next annual meeting
13. Unfinished business
14. New Business
15. Adjournment, *sine die*

1974 Committees of the House of Delegates

COMMITTEE ON CREDENTIALS

Edward DuVivier, *Co-Chairman,* (DS)
Henrietta Herbolsheimer *Co-Chairman,* (CMS)

Charles A. DeKovessey (DS) — John P. Pope (DS)
Helen Newman (CMS) — Mathew W. Kobak (CMS)

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

COMMITTEE ON RULES & ORDER OF BUSINESS

A. Everett Joslyn, *Chairman* (CMS)

Anthony G. Cesare (CMS) — Frank J. Saletta (CMS)
A. J. Kiessel (DS) — Paul Lorenz (DS)
W. R. Fleischer (DS)

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

TELLERS AND SERGEANTS AT ARMS

Wayne Leimbach, *Chairman* (DS)

Julius E. Ginsberg (CMS) — Herbert Fine (DS)
Hernan Reyes (CMS) — George Shimkus (DS)
Clarence A. Norberg (CMS)

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

REFERENCE COMMITTEE ON GOVERNMENTAL AFFAIRS & MEDICAL-LEGAL

Theodore Grevas, *Chairman* (DS)

David Helberg (DS) — Julian Buser (DS)
Leon Ampel (CMS) — James FitzGibbons (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

Medical-Legal Council
Governmental Affairs Council

Standby:
P. John Seward (DS)

REFERENCE COMMITTEE ON ECONOMICS, PEER REVIEW, SOCIAL & MEDICAL SERVICES

John Ovitz, *Chairman* (DS)

A. Beaumont Johnson (DS) — James Reid (DS)
Roland R. Cross (CMS) — Raymond W. Nemecek (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

Committee on Drugs & Therapeutics
Council on Economics & Peer Review
Council on Social & Medical Services
Government Health Programs Reimbursement Committee
Health Care Finance Committee
Director, Illinois Department of Public Aid
Director, Illinois Division of Vocational Rehabilitation

Standby:
N. Frank Holman (DS) — James Borgenson (DS)

REFERENCE COMMITTEE ON EDUCATION AND MANPOWER

Morris K. Friedell, *Chairman* (CMS)

Donald Edwards (DS) — Daniel J. Murphy (CMS)
Ross Hutchison (DS) — Loren B. Horton (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

Council on Education and Manpower
Illinois Council on Continuing Medical Education
Illinois Department of Registration & Education
Student Loan Fund

Standby:
O. W. Pflasterer (DS) — F. H. Riorden (DS)

REFERENCE COMMITTEE ON ENVIRONMENTAL, COMMUNITY & MENTAL HEALTH

J. Robert Thompson, *Chairman* (CMS)

Edward Ference (DS) — Vincent C. Sarley (CMS)
Kermit Mehlinger (CMS) — William Frymark (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

Council on Environmental & Community Health
Council on Mental Health & Addiction
Director, Illinois Department of Public Health
Director, Illinois Department of Mental Health
Director, Illinois Department of Children & Family Services

Standby:
M. J. Carlisle (DS) — Walter Brill (DS)

REFERENCE COMMITTEE ON FINANCES, BUDGETS AND PUBLICATIONS

C. Otis Smith, *Chairman* (CMS)

Frank J. Kwinn (CMS) — Guy Pandola (DS)
James C. Parsons (DS) — Harold L. Jensen (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

Educational & Scientific Foundation
Finance and Medical Benevolence Committee
Publications Committee
Treasurer
Budgets prepared and approved by Board of Trustees

Standby:
James Sutherland (DS)

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

James Laidlaw, *Chairman* (DS)

Herschel Browns (CMS) — Loren Boon (DS)
John S. Hyde (CMS) — G. W. Giebelhausen (DS)

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

Standby: George Mitchell (DS)

REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND ADMINISTRATION

John Ring, *Chairman* (DS)

Charles White (DS) — Allen C. Hrejsa (CMS)
Joseph H. DeCarlo (CMS) — Alan M. Taylor (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

President	Policy Committee
President-elect	
1st Vice President	
2nd Vice President	Advisory Committee to
Secretary	Woman's Auxiliary
Chairman of the Board	
Trustees from the 11 districts	Ethical Relations
Trustee-at-large	Committee
Speaker of the House	
Vice Speaker of the House	Committee on Physician Competence
Chairman, AMA Delegation	Committee on Committees
Executive Administrator	
President, Woman's Auxiliary	Committee on Redistricting and Tenure

Standby:
Mark Hollowell (DS) — William Perkins (DS)

REFERENCE COMMITTEE ON PUBLIC RELATIONS, MEMBERSHIP AND MISCELLANEOUS BUSINESS

Lawrence Hirsch, *Chairman* (CMS)

E. J. Kotanyi (CMS) — Kenneth Kaufman (DS)
Vincent C. Freda (CMS) — George Wilkins (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the reports of the following committees and upon any other matters referred by the Speaker:

Insurance Committee
Council on Public Relations & Membership Services
Council on Affiliate Societies

Standby:
W. W. Davidson (DS) — Antonio Boba (DS)

Officers and Administration

President

In a very short time my year as president of the Illinois State Medical Society will come to an end. These past months have been busy and challenging, and I regret that they have sped by too quickly to fulfill goals I set at the beginning of my term.

My principal goal was to unify as best I could the medical profession in Illinois . . . to strengthen it . . . and to increase its effectiveness. This was the message taken to physicians through the medium of the President's Page in the *Illinois Medical Journal*, in visits to county medical societies, and talks with medical leadership in each of our trustee districts.

I believe that, among the many challenges facing the medical profession, the most serious is the government's program for Professional Standards Review Organizations (PSROs). Under PSRO law, the medical profession was assigned the responsibility of assuring an effective, efficient and economic delivery of high quality care under Medicare and Medicaid. We were given two years to do the job, with the threat of government intervention at the end of that time. ISMS moved quickly to build a statewide review mechanism upon the solid foundation provided by the successes of the Hospital Admissions and Surveillance Program being conducted by the Illinois Foundation for Medical Care. At this writing, federal designation of seven PSRO regions in Illinois has disrupted our effort to achieve the unified, statewide program desired by most of the state's physicians and by others involved in health care.

Despite this setback, and the uncertainties which lie ahead, Illinois has had a voice in the development of PSRO standards and regulations. Your president was privileged to represent organized medicine in Illinois as a member of the National Professional Standards Review Council. The council was formed to advise the Secretary of Health, Education and Welfare in developing PSROs upon the scant framework outlined in 1972 amendments to the Social Security Act. Although much of the council's advice has gone unheeded by Washington bureaucrats, we have been able to influence HEW thinking on some issues, to the benefit of the practicing physician.

As I travelled throughout the state on the traditional President's Tour, my colleagues were urged to support the ISMS concept of a single, unified PSRO in Illinois, and to implement this concept by forming Local Medical Review Organizations (LMROs) through which local physicians and osteopathic physicians would perform medical review functions. It is encouraging that many of our county medical societies heeded the message and have acted to initiate LMROs.

Throughout my many years in organized medicine, my actions always have been guided by opinions and concerns of practicing physicians. During the President's Tour, I listened and learned as I met with my colleagues in 16 counties. In addition, I participated in 11 meetings with district trustees and medical leaders from several other counties. From these meetings ISMS has gained valuable insight into the problems and issues which trouble physicians in these chaotic times. The press and broadcast media seem to be concerned about the problems affecting health and medical care, and sincerely interested in what the physicians of Illinois are doing to solve these problems.

I was especially gratified by the news media's response to the "Physician's Bill of Rights." I drew up the "Bill of Rights" because it seemed time for physicians to stand up and be counted . . . to say "Enough!" to increasing demands upon the health care system . . . to more and more intervention by government and other third parties . . . and to the harassment of physicians through groundless malpractice suits. Reporters and news broadcasters correctly interpreted the "Bill of Rights" as a shield for the patient, protecting the traditional, confidential relationship with his physician.

Physicians, too, responded with gratifying support, and the "Bill of Rights" was introduced in the House of Delegates of the American Medical Association. The resolution embodying the "Bill of Rights" now is under study by the AMA Committee on Medical Service, which will report on the resolution during the Annual Convention next June in Chicago.

Last May, I served as moderator at a meeting of ISMS leadership, our Committee on Health Care of the Poor, and representatives of more than 40 community organizations, health agencies and volunteer groups. The conference sought to identify major health problems of Chicago's poor, and to explore ways in which they might be solved. Two of the major problems were lack of coordination of health and medical services, and difficulties in making the poor aware of programs and services available to them. ISMS was urged to take the lead in coordinating and publicizing the wide range of available services. Staff began to explore ways in which your medical society could carry out this responsibility; the search led to the Council for Community Services in Metropolitan Chicago. This organization has had many years of experience in operating a referral service which was seen as a proper foundation for a medical information service. Discussions with the Council have led to development of a joint ISMS-Council proposal for a 24-hour telephone "HOTLINE" which would provide medical and health information to all residents of the metropolitan area. It is hoped that this project will be brought to fruition within the next few months.

Among my most pleasant duties this past year was the responsibility of representing ISMS to other medical organizations, and to represent Illinois physicians at various important events and functions.

The time is near for me to step out of the limelight

I have enjoyed as your spokesman, representative and servant. I am proud of my profession and my colleagues in ISMS. I have endeavored to serve to the best of my ability; in the months and years ahead it is my hope that I can continue to serve ISMS in the political arena, in its efforts to develop a PSRO acceptable to physicians, and in its attempts to improve the health care of the poor. Indeed, I will be happy to serve wherever I can best help.

I offer my deepest thanks to our society's leadership, our members, our invaluable Auxiliary, and to Roger White and his staff—especially Ned Stuppy and Shideler Harpe of our Division of Public Relations, who did so much to smooth my path.

To all of you, my warmest regards, and my compliments and very best wishes to my successor, Fredric D. Lake, M.D.

Willard S. Scrivner

President-Elect

Your President-Elect has been devoting his apprenticeship and insight into the operation and program of the Illinois State Medical Society and the problems posed for organized medicine by federal and state government. In so doing, he has been involved in seeking a cohesion and unity of purpose among component societies and the state society.

On several occasions when your president was otherwise committed it has been a pleasure to serve as your official representative to the medical societies of neighboring states as well as to agencies and organizations within the state.

Fredric D. Lake

First Vice-President

The office of First Vice-President has permitted me to participate in and contribute to the activities of the Executive Committee and the Board of Trustees. This year has provided the opportunity to contemplate and reflect upon the problems facing medicine in particular, society in general and signs for the future.

The outlook is pessimistic and frustrating. The high cost of living and continuing inflation, the standards of honesty in America, the lack of faith in American institutions and declining confidence in government contribute to a gloomy outlook.

Keeping the peace, population, pollution, irreplaceable natural resources and the rich-poor gap are urgent problems of global proportions. Yes, some action has been taken on these problems, but they cry for more concern and positive progress.

Medicine and its practitioners are a part of the society in which these problems and pessimism abound, and surely, it seems, we reap the whirlwind of agonies suffered by our fellow men who labor for solutions and relief.

Medicare, Medicaid, HMO's PSRO's National Health Insurance—all in the name of quality assurance, cost control and health equity. Quality assurance of medical care will do little more than identify care that is only as good as it need be, and not one bit better! Health equity for the impoverished, malnourished and unskilled is a cruel political hoax! Recent polls indicate that a large segment of our society requests and will accept a quantity of medical care for a predetermined and pre paid fee. To accept should be their perogative, so long as freedom of choice is guaranteed for both consumer and provider.

Historically, legislation and supporting regulations to solve a medical problem are destined for failure. Physicians should have no anxiety about laws and regulations as long as we oppose, reject and not comply with those that are not in the best interest of society's health care, and we base our professional judgement and actions on what is right for the patient.

In Illinois we need to continue developing our program for establishing criteria for patient admission, diagnosis, treatment, results and length of stay. These are the criteria for critical peer review. Couple these with selfassessment and programs of continuing medical education. Then we will have an unassailable program for quality medical care.

We need to exert continuing leadership to improve health care to the poor and maldistribution of doctors. The solution to these vexing problems will require the combined effort of local social agencies, educational systems, industry, housing authorities and physicians acquainted with the local conditions working with the local people, and not promulgations from the castles of government. We are active in this area, but we could do more.

We of ISMS need to build on the program of unity and strength of Dr. Scrivner's. We must get better input from the practicing doctor. ISMS officers and staff must improve the channels to and from component society's presidents who in turn must be responsive to the needs and attitudes and opinions of the members. In this manner we could disseminate information and retrieve the "grass roots" answers and guidance rapidly.

We need redistricting, from the bottom up. If the practicing physician is not part of a broad base, he looses his representation. He should be part of a medical service area that would be large enough to represent him, but small enough for his voice to be heard. ISMS officers should propose a basic plan, and ask the doctors to work out their best structure.

What of the future? At present the slow pace of attacking our serious problems would suggest collapse in 30-100 years depending on the rate of population growth. Medical care relates to all of the problems and vice versa. I believe that the contributions of medicine can detour that depressing course. I know we can if we maintain our faith in honesty, responsibility and freedom.

Paul Sunderland

Second Vice-President

There was not much required of me during the year.

As an adviser to the President and the Public Relations Council, I found time to attend only one meeting during 1973, but I did attend the January, 1974 meeting.

One of the programs sponsored by the Council is "Dr. Sims Talk to Teens." It was my pleasure to edit the publication articles which will appear in the high schools in the state during the 1973-74 school year. This program has been well received over the many years, and it should be continued on an ongoing basis.

I attended the summer meeting of the Board of Trustees but was unable to attend the fall meeting because of other obligations. I was in attendance at the Board Meeting in Washington, D.C., in February.

It was my honor to represent the Illinois State Medical Society at the first convocation of the Public Health Department of the University of Illinois. This was the first convocation of the department which granted Master Degrees to some 20 candidates.

Otherwise, this has been an easy, but never-the-less interesting, year as your Second Vice-President.

Charles J. Weigel

Secretary-Treasurer

The report of the Secretary-Treasurer will be found under Finances and Budgets, page 235.

TRUSTEES

First District

After each ISMS Annual Meeting, there are gratifying requests for interim meetings from the delegates. There is high interest in maintaining the momentum and firm resolve, the sense of accomplishment. Two district wide meetings were held in 1973—both poorly attended. It could be said that the district is too wide, the travel time too great. Possibly, but there is no finer group of delegates in the state than those of the First District and they must be kept informed! To this end, your trustee visited most of the counties in the district during the fall of 1973. The "feedback" and exchange of ideas provides the basis for representation on the Board of Trustees.

In common with other districts the First District has been divided by the state of Illinois regions, the foundation movement, and PSRO. Such administrative divisions are not incompatible with ISMS trustee districts—if the physicians resist the inclination to become provincial. The strength of organized medicine lies in the county medical societies; the danger lies in the submerging of these societies in a "super" regional society which becomes dependent on government for existence.

Your trustee has been privileged to be named to the Board of Directors of the IFMC and to serve on its Executive Committee as well as that of ISMS. This has meant a busy year, but time well spent in the never ending task of safeguarding the trust which our patients have placed in us.

Joseph L. Bordenave

Second District

In my three years as a Trustee, I have been astounded by the rate of progressive loss of control of the practice of medicine the doctors have accepted. Everyone from hospital boards, to government dictatorial agencies, to community groups, to insurance companies, is claiming to be a better choice to deliver medical care to the people. Are the doctors going to realize that, in fact, only doctors can provide medical care?

Can we unite to resist the progressive take-over of the delivery of medical care by other than practicing physicians? Should we strengthen the unity of organized medicine? I think these are questions the practicing physicians should ask themselves, and make their answers known to the leadership of the ISMS.

What would happen if the doctors went on limited strike; that is, refused to provide any service not related to the medical needs of the patients? Under such a limited strike, doctors would continue to treat patients according to their needs, but would refuse to complete any forms for certification or utilization review or justifying services to an insurance company, government agency or local committee. Such an action could create chaos for the bureaucrats, while simultaneously improving the delivery of medical care by making available more time for care of patients.

Allan Goslin

Third District

In addition to the supplemental reports, there will be a Third District report filed with the House of Delegates.

I have attended the meeting of the U. S. Pharmacopeia Convention at which after considerable debate the proposed merger with National Formulary was again called off. My second major activity on behalf of the Board of Trustees has to do with continuing negotiations with the State of Illinois with respect to controlled substances. So far, ISMS has been successful in preventing the requirement of triplicate blanks for all of the amphetamines, Ritalin and short-acting and intermediate-acting barbiturates, with the exception of the soluble amphetamines to which we had agreed a long time ago. Negotiations are still continuing, however, along these lines.

Joseph H. Skom

During 1973 my attendance has been consistent for all meetings of the following: Board of Directors of Illinois Foundation for Medical Care; Finance Committee of IFMC; Board of Directors of the Chicago Foundation for Medical Care; Third District Trustee of CFMC; ISMS Board of Trustees meetings; Delegate to ISMS House of Delegates; and I have served on the ISMS Publications Committee, Economics and Peer Review Council and Medical Legal Council.

I have attended various branch meetings and given discussions for current and up-to-date information as to the activities of the Board of Trustees and a projection of the future in medicine.

Frederick Weiss

Fourth District

This has been a year of many activities on varied subjects for the Fourth District. On the educational front, Peoria School of Medicine has moved forward in a considerable effort to alleviate the manpower shortage in the 1B Region. Presently enrolled are 40 sophomores and 30 junior students. Four graduate programs are now under the educational auspices of the Peoria School of Medicine, and a Family Practice Residency designed to meet the need for family practitioners in this area has eleven Residents in the training program.

The Board and ISMS committees have been active as in past years, and I continue to serve on these committees as member and consultant as well as serving on the State HASP Committee and the Joint Practice Committee of ISMS and INA. Two delegate meetings within the District were held in the last year, and several visits to county medical societies have been made to better ascertain the feelings of the membership within the counties.

In the year ahead there will be even greater challenges to be met from governmental encroachments into the field of medicine; the greatest challenge of all will be to preserve the best parts of the fee-for-service system of medicine, as we know it, while accepting what changes are necessary due to the increasingly larger part that government will pay in medicine. This challenge, I am sure, can be met by the physicians of the Fourth District with the help of our able county executives and ISMS staff. It has been my pleasure to serve this District in the years past.

Fred Z. White

Fifth District

The past year saw many gains in the Fifth District as far as unity of thought was concerned. We have had two well attended district meetings, featuring Philip Thomsen, M.D., on the PSRO situation, and ISMS President, Willard Scrivner, M.D.

I would like to point out that our leaders are doing a valiant job keeping the members of our society informed as well as influencing medicine in general.

Our downstate medical schools at Springfield and Urbana-Champaign are growing steadily. It is devoutly hoped that suitable financing of these schools will be continued, for the education they are giving is the kind that so many of us practicing physicians would like to encourage.

A. E. Livingston

Sixth District

A meeting of the Sixth District delegates will be held in early April, 1974, in Chicago, immediately before the Annual Meeting of the Illinois State Medical Society; all delegates from the Sixth District are urged to attend. The quickening pace of governmental intrusion at all levels on the practice of medicine makes it even more important that organized medicine remains strong and represents the best interests of our members and the public in general. Excellent leadership in this regard has been exerted by our President, Willard Scrivner, M.D., during the past year. His visit at Edwardsville in September, 1973, brought out the largest attendance in the district for many years.

In 1973 no problems arose in the Sixth District which required the attention of the various District Committees.

Considerable activity in the Sixth District during the past year resulted in two important accomplishments: (1) formation of the Western Illinois Foundation for Medical Care in Quincy, and (2) passage by the state legislature of an extension of the Good Samaritan concept to all emergency situations in the hospital.

There remains considerable dissatisfaction with both the low IDPA fee allowances and the discriminatory Federal freeze on fees in the face of rapidly escalating costs.

The greatest concern, of course, centers about the PSRO legislation and the major disruptions it promises to bring in the efficient delivery of health care. The doctors are being required to police the abuses and excessive costs of a law which was poorly conceived in the first place and has been misrepresented to the public by legislators and social security employees.

To end this report on a brighter note, I would like to extend my thanks to all doctors in my district for the aid and support extended to me in the year past and to voice my appreciation for the many favors done for me by the hard working members of our staffs in both the Chicago and Springfield offices.

Mather Pfeiffenberger

Seventh District

District Committees on Ethical Relations, Grievance and Prepayment Plans had no call for meetings during the year.

The Executives of the Eleventh and Seventh District Societies were polled by telephone. The Fee Freeze has aggravated many of the practitioners; Illinois Public Aid is being criticized by many because of delay in payments; and the shortage of manpower in Clay and Shelby Counties was noted.

Trustees during the poll regarding the "Noncompliance and Repeal" revealed universal acceptance and agreed that PSRO is a bad law.

Your Trustee must take this opportunity to praise President Willard C. Scrivner, M.D. His address to the Christian County Medical Society in November regarding PSRO and his last address before the Macon County Medical Society on January 22, 1974, were most factual with the updated patterns for action.

An interesting note, the M.D.'s in this District who have been in practice 15 or more years look with dismay and apprehension as to the future of medical practice. Many of them have been desirous of having their sons follow them in the profession, but have changed their minds.

The work of the Compotent Societies as well as their Auxiliaries is deeply appreciated.

Arthur F. Goodyear

Eighth District

During the past year, the Eighth District has been represented, to the best of my ability, at each Board Meeting. When possible, I have met with component societies, which I contacted by phone on several occasions. ISMS members in the Eighth District have been subjected to my efforts to make of them political activists, as well as involved and vocal members of the society.

We hope to see new young faces among the old representing our Trustee District in the House each year. On the other hand, moreover, the Eighth District expects to keep the older, experienced hands as active as ever in the affairs of ISMS.

Eugene Johnson

Ninth District

Throughout the past year I have attended all of the Illinois State Medical Society Board of Trustee meetings. On August 6, 1973, we had a Ninth District trustee meeting concerning PSRO in Marion. On October 3, 1973, there was a trustee meeting of the Ninth District in Mt. Vernon, and this was held in conjunction with the Illinois State Medical Society President's tour, featuring Willard C. Scrivner.

I also visited and attended the following county society meetings: Jefferson-Hamilton, Franklin, and Saline, Pope and Hardin County. In November, 1973, I attended the Southern Illinois Medical Society meeting in Belleville and participated in the business meeting and discussion.

On November 20, 1973, I called and attended a meeting of the Presidents, Secretaries, Delegates and Alternate Delegates of the counties in the Region 5 HASP Program. Discussion was held concerning PSRO program. At this meeting it was approved to proceed in obtaining a non-profit charter for the area of HASP Region 5.

I discussed the problem with officers of two of the counties in the Ninth District concerning election as President of the county medical society a physician not a member of the Illinois State Medical Society; to date this problem has not been fully resolved. Discussion also was had with one small county medical society in regard to their joining a neighboring county society.

I am pleased to report that during the year 1973 there was no cause or necessity for calling a meeting of the District Peer Review or Ethics Committees.

Warren D. Tuttle

Tenth District

During 1973-74 we have had considerable activity in the Tenth District in regard to PSRO. We established a "Not for Profit" Corporation with the idea of implementing PSRO on a local level. This now has questionable merit. Subsequently, St. Clair County Medical Society unanimously passed a resolution on "non compliance" with PSRO. A resolution requesting repeal of Public Law 92-603 (HR-1) has been submitted for the next meeting of the House of Delegates of ISMS. The other Counties in the District are planning to take action in the immediate future.

The Southern Illinois Medical Association, which encompasses Districts 9 and 10, had its annual meeting on November 8, 1973. The question and answer period was quite interesting and a discussion regarding a change in the selection of AMA Delegates is worthy of further consideration.

We have attempted to have meetings of the County Delegates and Alternates on three different occasions. The response was most disappointing, but we intend to keep trying.

It is my impression that the goal of District 10 is to stay united and continue to express its most sincere opposition to PSRO. Since it is the feeling of the Membership that this Legislation is not in the best interest of Medicine in the USA, it is mandatory that each individual member make his feelings known to his patients, to his political representatives and to his colleagues.

Herbert P. Dexheimer

Eleventh District

Organized medicine today has probably the most complex and difficult problems in its entire history. To write a "position report" at any given time during the past three terms that I have been privileged to be a Trustee of the Eleventh District would be somewhat presumptive. (Please note that this report was prepared January, 1974.)

Current issues are multiple; a brief explanation of the issues follows:

1. *PSRO (P.L. 92-603)*: The ISMS posture will have been reestablished by the anticipated special meeting of the House of Delegates.
 Currently, I favor the position of
 a. Seek to *repeal the law.*
 b. Promote a wide campaign to elaborate on the deleterious effects of the law to the public and the profession.
 c. Make hospital Utilization Review Staff Committees in conjunction with local, county medical society organizations function in a way that would demonstrate public accountability. Thus, they would be so unassailable that they *must* be accepted as equivalent to (but not as *implementing*) a PSRO unit.

2. *HMO Legislation:* Recently SB14 signed into law by the President. Here the mechanism of providing "start up" funds for prepaid HMO's has been clearly established. Medicine's answer by the solo or small group clinics (*if* this mechanism of Health Care Delivery becomes widespread) is still to be delineated. So far there has been very little discussion generated by this bill.

3. The role of *fiscal intermediaries* as related to their attempts to delineate the UCR fees as being "payment in full" for services charged has occupied considerable time by the ISMS Committee On Health Financing. PL 92-603 has a most important subsection 213 with respect to the role of fiscal intermediaries, in the retrospective denial of payments to hospitals and physicians.

4. Recent hospital board of trustees efforts to dictate to the medical staffs of their hospitals the selections of medical staff departmental heads and partially subsidizing them by salary is under active scrutiny by the ISMS.

5. The role of Foundations, both local and state, has to be reassessed in light of Federal legislation, viz. the PSRO law and the recent HMO law already mentioned.

6. Medical education, distribution of physicians, the "primary physician" as compared to the "family physician," the rural health systems, emergency medical systems, hospital based physicians—have been recognized as problems, with many more having been ongoing and discussed by your ISMS Board, by councils and committees.

From an organizational standpoint several issues are currently before the Board:

1. The redistricting of county medical societies.
2. The establishment of District Boards to keep communications more actively open to the county medical societies and to maintain wider participation on the part of local medical societies, and
3. Tenure of office of various officers and trustees. (I feel that more active participation by more doctors is a must in order to maintain a more viable and responsive medical society.)

During the past year I attended all the meetings of the ISMS Board of Trustees, as well as the AMA meetings in New York and Anaheim. I served as Chairman of the recent "Committee on Health Financing", Chairman of the Bylaws Committee, and advisor to the Council on Economics and Peer Review. It also was my duty to serve as ISMS representative on the "Committee for Efficient Use of Health Care Delivery," consisting of H.I.C., Blue Cross and Blue Shield, and American Hospital Association representatives.

In June, 1973, I was replaced as President of the IFMC by Phil Thomsen, M.D., and am currently on the IFMC Board.

I further served as a representative of the AMA House of Delegates to the National Advisory Committee of the AMA on PSRO and have been assigned the task to study the "Structure of a PSRO." This does *not* imply endorsement of the PSRO law, however, but is in keeping with the 1973 posture of both ISMS and the AMA to have physicians work within the framework of the law "constantly to oppose any facets of the PSRO legislation which acts to deteriorate quality care; to publicize such deleterious facets; and place highest priority on developing and pursuing appropriate amendments to preserve high quality of care."

This being my stated last term as Trustee of the Eleventh District, I would be remiss in not recognizing several facts.

The duties of a Trustee are not always easy to fulfill—the personal demands on one's time; the attempt at being representative of all the constituent medical societies; the keeping current on all the issues that arise; and maintaining an active organization with fiscal responsibilities have been challenging—sometimes rewarding and sometimes defeating. I always have maintained that one must stay well within the mainstream of medicine, avoiding the extremes of right or left in his decisions. I appreciate your trust and confidence in me during the past nine years.

Joseph R. O'Donnell

Trustee-at-Large

"Charge!" That's a common expression heard at various sports events of late. And that's what medicine had better do. The activities of the government to regulate and dictate the practice of medicine are intensifying—so we'd just better intensify our efforts to guarantee patient freedom of choice as well as the fee-for-service entrepreneurial system of medical practice.

My year as immediate past-president, which places me into the category of the "also was's," has given me the opportunity to sit back and get a slightly different perspective on the affairs of medicine. I also have tried to reflect the views of the membership as they were indicated to me during my tenure as president. And these views, from this perspective, have helped to mold the direction and thinking of the Board and its committees as it addressed implementation of policies and programs.

Fellow physicians, even though we have had a great deal of discussion with you, even though we have tried to make your viewpoints known forcefully to the social planners and bureaucrats, even though ISMS has established organizations to provide the mechanisms to do what we're being told should be done—medicine is taking more than its share of bumps. HMO, PSRO, MEDICHEK, Perinatal Centers, and all such activities by the government, have been pursued and debated aggressively on your behalf. But it cant' be done alone, by the Board, or by ISMS. Any activity or change must be supported by action all fronts—*you,* each member, and *we,* collectively, can make things happen, or prevent them from happening.

Tell your congressman, tell your state legislator your views. Tell your county and state medical societies. By dint of action we can preserve what we believe to be good.

And while I'm on this point, I want to emphasize the importance of IMPAC. If we are to be heard and recognized, this is one means of doing it. Membership in IMPAC reflects your concern for good government. Bi-partisan and effective, enlargement of its rolls will help every member. Those who are members are supporting those who are not members, since IMPAC works for the good of all physicians. Consider that, and if not now a member, please join. We can do so much together.

I enjoyed my tenure as president and now as Trustee-at-Large. It has been a distinct pleasure to work with the dedicated physicians and staff who are the state medical society. Hopefully, I will be able to continue to work for the good of medicine in Illinois and I pledge to contribute whatever I can in my future activities.

When I started out I said "Charge!" And I meant it. We want to win, of course, but win for the people of Illinois the best health care and health care delivery which can be achieved. We'll never get anyplace just jogging along. We must keep on truckin'. "Charge!"

Frank J. Jirka, Jr.

CHAIRMAN OF THE BOARD OF TRUSTEES

During the past year, your chairman endeavored to implement the House of Delegates directives as effectively and efficiently as possible and make ISMS a more potent force in the state's legislative and socio-economic circles. I am pleased to report that all directives of the 1973 House of Delegates have been, or are, in the process of being implemented.

Following are some of the more significant developments resulting from Board of Trustees actions which may not be covered in the various council and committee reports to the House. I am pleased to report that:

1. ISMS increased its membership to an all-time high of 11,392 as of December 31, 1973. As a result, the society was honored by the AMA for achieving "the greatest numerical increase in membership of any state medical society in the country."

2. A special Task Force on Early Periodic Screening, Detection and Treatment was established to develop a statewide educational conference on EPSDT (MEDICHEK) and select an Illinois community for a pilot project. The Task Force, chaired by Lawrence Hirsch, M.D., Chicago, organized a successful conference which drew over 100 physicians. It also selected Will, Grundy and Kankakee counties as the area for the proposed pilot project which, if successful, will be used by the U.S. Department of HEW as an EPSDT model program for communities throughout the country.

3. The Board created a special Committee on Quackery & Unauthorized Practice of Medicine to function as an educational & monitoring group and initiate action against cultist groups.

4. A Physicians Competence Committee was created to develop a mechanism to review the problems of physicians practicing unethically or with limited abilities as a result of age or addiction to drugs.

5. ISMS sponsored a Leadership Conference on Malpractice and Legislation which drew more than 200 physicians.

6. Over 1,100 ISMS members and their families were provided with eight outstanding travel seminars to South America (3), Europe (2), Scandinavia, South Pacific and the Orient.

7. ISMS sponsored the third annual Doctor's Job Fair, which attracted 58 exhibiting communities and 150 job seeking physicians.

8. We were instrumental in getting dozens of ISMS members appointed to state licensing boards, advisory committees and various other state posts.

9. The Board conducted an "Open Forum" at its October, 13-14, meeting in Rock Island to provide county medical society leaders in the Fourth District with an opportunity to personally air their problems and concerns.

10. I'm also pleased to report that ISMS conducted one of its most effective legislative programs in recent history. The society was instrumental in: (A) repealing a 1971 act which required women planning to marry to be tested for immunity to rubella; (B) expanding the "Good Samaritan" concept to exempt from civil liability MDs who provide emergency care anywhere, at any time; (C) freeing MDs of the additional paperwork and threat of investigations involved in prescribing many items under Schedule II of the Illinois Controlled Substances Act; and (4) helped "kill" many other bills which the society believed to be bad legislation.

Recommendations for the future:

1. Provide guidance to medical staffs in their negotiations with hospital governing boards to protect the rights of physicians.

2. Continue the practice of "Open Forums" at all downstate meetings and at least one Chicago meeting of the Board of Trustees each year; they have proved extremely valuable in providing the Board with an insight into the concerns of county and branch societies.
3. Make ISMS a more effective force in the AMA House of Delegates by better utilizing the knowledge and experience of ISMS officers, trustees, council and committee members.
4. Continue, and perhaps increase, assistance to the ISMS Woman's Auxiliary and the American Association of Medical Assistants, Illinois Chapter.

William M. Lees

SPEAKER OF THE HOUSE

There is no report at this time.

Andrew J. Brislen

VICE SPEAKER OF THE HOUSE

Following the 1973 House of Delegates adoption of Constitution and Bylaw changes, the Vice Speaker is a member of the Board of Trustees. It has been my privilege to serve the ISMS by attendance and participation at the Board meetings. I have been greatly impressed through this participation in and exposure to Board proceedings; both by the volume of work and deliberation that takes place as well as by the diligence of Board members on behalf of the membership of ISMS. In addition, I have served as a member of the Publications Committee of ISMS this year.

The challenging preparation for the 1974 Annual Meeting has been the equitable selection of downstate delegates for reference committees. Since this is my first year as Vice Speaker, I have not had the opportunity to know some of the delegates and their interests. The downstate trustees have been helpful and I believe the distribution of these selections by district and county is as equitable as possible. Many counties do not respond early enough in notifying the ISMS office who their delegates and alternates are to be which creates difficulty in developing equitable representation.

In looking forward to the 1974 Annual Meeting of the House of Delegates, it takes no imagination to recognize that there are difficult problems to be faced and resolved. Delegates are urged to do their "homework" by familiarizing themselves with the "Delegates Handbook," "Your Role as a Delegate" and resolutions, attend District meetings, to take an active part in reference committee hearings where the action is and should be, and attend all sessions of the House of Delegates. County society representatives other than delegates should be encouraged to attend and take part in the reference committee hearings and be involved in the deliberation. In this way the democratic process is served. As the House of Delegates adopts certain policies or actions, it is imperative for the membership of ISMS to be unified in carrying out the policy and decisions.

My hope as an officer of the House of Delegates is to serve you by helping to accomplish a smooth functioning meeting, in order to obtain results that are representative of the wishes of the membership in the ISMS.

James A. McDonald

DELEGATION TO THE AMERICAL MEDICAL ASSOCIATION

The Illinois Delegation to the American Medical Association held pre-convention briefings with the ISMS Executive Committee before both the AMA annual and clinical meetings. On these occasions, reports and resolutions published in the handbook were discussed in conjunction with background reports prepared by the ISMS staff.

At the June meeting in New York, Morgan M. Meyer, M.D., served as a member of Reference Committee A (Insurance and Medical Service); H. Close Hesseltine, M.D., on Reference Committee G (Miscellaneous), and Theodore R. Van Dellen, M.D., on Reference Committee H (Miscellaneous).

At the clinical convention in Anaheim, William M. Lees, M.D., served on Reference Committee A (Insurance and Medical Service); Charles K. Wells, M.D., on Reference Committee E (Scientific-Public Health), and Maurice M. Hoeltgen, M.D., on the Reference Committee on Rules and Order of Business.

The Illinois delegation introduced nine resolutions at the June meeting and two at the clinical convention, where it was also one of six state delegations submitting an amendment to the controversial Board of Trustees Report EE, which established AMA policy on Professional Standards Review Organizations.

The AMA House of Delegates took the following actions on Illinois' resolutions:

I. Resolution A97: Referred to the Council on Medical Service with the request that it report at the 1973 Clinical Convention on the feasibility, plans and cost for the development of an AMA program for the special training of migrant health care volunteers. Prior to the opening of the Clinical Convention, members of the delegation testified before the Council on Medical Service on this and other Illinois resolutions referred to the council. In its report to the House, the council recommended that a nationwide health insurance program for migrants be developed in accordance with the principles contained in the AMA Medicredit proposal, and that such program should include a clear, acceptable definition of the term "migrant worker."

II. Resolution A98: Adopted and referred to the Board of Trustees resolving that the following basic Medicredit concepts be considered in any pending national insurance program:

1. That individuals should have available to them insurance protection, underwritten by risk-bearing insurance companies, providing comprehensive basic health protection and also including protection against the catastrophic costs of illness;

2. That pluralistic means of health care delivery should be afforded, with the individual having the freedom of receiving care from qualified providers of his choice;

3. That any federal funding should be provided through general revenues, with government subsidy or assistance related to the individual's ability to pay;

4. That cost sharing by the beneficiary, while fostering individual responsibility, should be reasonable and not act to prevent access to health care; and

5. That insurance policies or plans be accredited by appropriate government regulatory bodies, to make certain that all essential elements of a comprehensive health care package are covered by the insurance.

These Medicredit principles are to be communicated to appropriate members of the Congress, including mem-

bers of the House Ways and Means Committee and the Senate Finance Committee.

III. Referred to the Council on Medical Service **Resolution A99,** which called upon the AMA to consider developing a model health insurance plan on a national level or, if that is not practicable, assist state associations to draft models applicable to conditions in their own states. At the Clinical Convention, the Council on Medical Service suggested in its report that the AMA's Medicredit proposal serve as a model health insurance plan for national and local adaptation. The House subsequently adopted this report in lieu of **Resolution 99.**

IV. Amended **Resolution A100,** which called upon the AMA to adopt the Statement of Understanding used widely in Illinois, and approved a simple policy encouraging physicians to inform patients regarding their responsibility to the physicians.

V. Referred to the Council on Medical Service **Resolution A101,** which requested that the Department of Health, Education and Welfare be petitioned to add to its Medicare claim form the statement, "I wish payment for this claim to be made directly to my physician," and that HEW allow for this form of payment in addition to the existing methods—direct assignment of fees or negotiating with patient to collect fees paid to him (non-assignment). At the Clinical Convention, the House approved a Report of the Council on Medical Service pointing out that implementation of this resolution would require an amendment to the present law, which the Council believes would be an unwise effort at the present time.

VI. Referred to the Council on Medical Service **Resolution A102,** which requested the AMA to seek legislation that will permit public aid agencies to purchase for each recipient a comprehensive health care policy which provides for the broadest type of in-patient and out-patient health care benefits, including preventive maintenance, check-ups, and immunization, and that such legislation permit public aid agencies to provide cash grants to recipients in an amount calculated to meet the co-payment and deductible cost which will be required at the time any service is rendered to a recipient.

VII. Rejected **Resolution A103,** which called on the AMA to institute action that would result in a revision of the system of narcotic registration so that no more than three letters and four numbers would have to be memorized by physicians. The reference committee studying this resolution, while sympathizing with its intent, recommended rejection because the system has been in effect for three years and the cost of and the resulting confusion in a change at this time might be overwhelming. It added that consideration would be appropriate in the event that a proposal for a change in the system is recommended by the Bureau of Narcotics and Dangerous Drugs in the future.

VIII. Adopted a substitute for **Resolution A104** calling for support for medical staffs. The substitute states that the Association declares that any proposal or arrangement between a hospital board of trustees and its medical staff that conflicts with the AMA Principles of Medical Ethics is improper; that unilateral changes in medical staff bylaws by hospital boards of trustees also is improper, and that the AMA suggests the following preamble be included in all medical staff bylaws:

> "The hospital and the medical staff have a duty to cooperate in their mutual responsibility of assuring the highest quality of patient care standards within the hospital. Only physicians can practice medicine under the laws of the state. In those areas in which medical judgment and the evaluation of professional competence are involved, the hospital has a duty to rely upon the judgments and recommendations of the medical staff, to cooperate and to provide needed assistance with full understanding that the primary responsibility is that of the medical staff."

IX. Referred to the Board of Trustees **Resolution A105,** which called upon constituent societies of the American Medical Association to indicate their complete support for the vigorous position the AMA has taken in opposing new Rule 5-04 (Federal Rules of Evidence, suggested to replace existing Rule 27 of the Uniform Rules of Evidence of the American Bar Association), which would eliminate most provisions of confidentiality except in mental illness, by publicizing the matter in their own states and by writing their congressmen urging them to support the present Rule 27 which guarantees confidentiality of patient communications.

X. Referred to the Council on Medical Services **Resolution C19,** the Physician's Bill of Rights. The reference committee studying this resolution concurred with its principle and commended its author, Willard C. Scrivner, M.D., for the concepts expressed; it was recommended for further study by the council, which was instructed to report back to the 1974 annual convention

XI. Adopted **Resolution C20,** which asks the Council on Medical Services to request the Bureau of Health Insurance to allow Medicare payments to be made to a physician providing an injectable drug or biological, even though that physician may not administer or supervise the administration of that injectable.

At the Clinical Convention, where there were numerous resolutions introduced on the subject of Professional Standards Review Organizations, the House adopted a report of the Board of Trustees, which was amended by a joint action of California, Illinois, Michigan, Kentucky, Louisiana and New York delegations. This amendment states that the AMA affirms the following principles:

1. That the medical profession remains firmly committed to the principle of peer review, under professional direction, and

2. That medical society programs of proven effectiveness should not be dismantled by PSRO implementation, and

3. That the Association suggests that each hospital medical staff, working with the local medical society, continue to develop its own peer review, based upon principles of sound medical practice and documentable objective criteria, so as to certify that objective review of quality and utilization does take place; to make these review procedures sufficiently strong as to be unassailable by any outside party or parties; and that the local and state medical societies take all legal steps to resist the intrusion of any third party into the practice of medicine, and

4. That this House of Delegates, as individual physicians and through the Board of Trustees and its Council on Legislation, work to inform the public and legislators as to the potential deleterious effects of this law on the quality, confidentiality and cost of medical care; and the hope that the Congress in their wisdom will respond by either repeal, modification, or interpretation of rules which will protect the public.

The amendment is concluded with the statement that "The considered opinion of this House of Delegates is that the best interests of the American people, our patients, would be served by the repeal of the present PSRO legislation. It also is believed that this is consistent with our longstanding policy and opposition to this legislation prior to passage."

At the opening session of the House of Delegates in Anaheim, Willard C. Scrivner, M.D., ISMS President, presented to the AMA Research and Education Foundation a check for $180,000. It was announced that this check brought to $3,416,000 the amount contributed to AMA-ERF by Illinois doctors.

It also was announced that Harold A. Sofield, M.D., was attending the Anaheim meeting in his final term as a delegate. Dr. Sofield chose not to run for re-election; Frank J. Jirka, Jr., M.D., an alternate delegate, being elected to replace him. Fredric D. Lake, M.D., will fill Dr. Jirka's unexpired term as an alternate.

Carl E. Clark, *Chairman*
Edward A. Piszczek, *Secretary*

Committees of the Board of Trustees

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

While the Advisory Committee held only one formal meeting with the Woman's Auxiliary officers, informal assistance was rendered by committee members on several occasions throughout the year.

At its January 27th meeting with the Auxiliary, the Advisory Committee approved a recommendation to increase state dues from $8 to $10 per member. The proposed increase, which would be the first since 1958, will be considered by the Auxiliary's House of Delegates in April.

Impressed by the Auxiliary's February 28, 1974, Symposium on Health Education for Illinois Organizations, which ISMS co-sponsored, the Advisory Committee also approved, in principle, co-sponsorship of a similar seminar in 1975.

As in the past, the Auxiliary again proved effective in raising funds for the AMA-ERF and the ISMS Benevolence Funds. Last year, it contributed $13,660 to AMA-ERF and $9,182 to the Benevolence Fund.

The Advisory Committee is grateful to Auxiliary President Mrs. Robert Hartman, her officers and the entire Auxiliary for their tireless efforts in support of ISMS and its activities.

Fredric Lake, *Chairman*
Willard C. Scrivner — William M. Lees

CONSTITUTION & LAWS

All amendments to the Constitution and Bylaws ordered by the 1973 House of Delegates were made in the copy of the Constitution and Bylaws published in the October, 1973, Reference Issue of the *Illinois Medical Journal*.

The committee considered the suggestions of the 1973 Reference Committee on Amendments to the Constitution and Bylaws and the instructions of the Board of Trustees in proposing additional amendments which will be presented to the 1974 House of Delegates in resolution form.

A plan to establish a district organization within each ISMS trustee district has been discussed at length by this committee and it is hoped that this plan will be given consideration by delegates and county medical society officers during the coming year.

Joseph R. O'Donnell, *Chairman*
Herbert Dexheimer — A. Edward Livingston
Allan L. Goslin — Warren D. Tuttle

COMMITTEE ON COMMITTEES

The Committee on Committees did not have any business referred to it during 1973 nor did it have any occasion to meet. The chairman of the committee served as a member of the Committee on Constitution and Bylaws and, as such, was able to monitor any matters pertaining to committees, but none of these appeared to require the services of the Committee on Committees.

Allan L. Goslin, *Chairman*
George Shropshear — Philip G. Thomsen

ETHICAL RELATIONS COMMITTEE

Only one case was appealed to the ISMS Ethical Relations Committee in 1973-74. Since the hearing on that case is still pending, the results will not be available until shortly before the annual meeting of the ISMS House of Delegates.

Paul Sunderland, *Chairman*
Joseph Skom — Arthur Goodyear
Joseph O'Donnell

COMMITTEE ON GOVERNMENTAL HEALTH PROGRAM REIMBURSEMENT

The Committee on Governmental Health Program Reimbursement has the responsibility of considering problems of physician reimbursement by Medicare, Medicaid and CHAMPUS. Committee members meet with representatives of the governmental health programs to discuss problems of general policy and specific complaints from ISMS members.

During the year, the Committee met with the Illinois Department of Public Aid and Mental Health concerning regulations that limit psychiatric treatment of Medicaid patients. Representatives of these departments agreed that consideration should be given to relaxing present limitations which place a $300 annual maximum per patient for psychiatric treatment. IDMH also agreed to discuss ways to relax the 10/20 day maximum stay for psychiatric inpatient hospital care.

The Committee called IDPA's attention to several physician complaints involving delays in claims payments. The Department agreed to the validity of the complaints and said efforts are being made to reduce the claims processing time to 35 days.

Because of the many objections by physicians to the present IDPA claim form, the Committee suggested that the Department consider using the new AMA standard claim form. IDPA representatives agreed to consider the new form as a possible replacement.

Philip G. Thomsen, *Chairman*
Herbert Dexheimer — George Shropshear
Eugene P. Johnson — Warren D. Tuttle
Frederick E. Weiss
Consultant
Jacob E. Reisch

POLICY COMMITTEE

Following the 1973 Annual Meeting, all resolutions and other matters passed by the House of Delegates pertaining to policy were reviewed by the Policy Committee. This Committee then developed policy statements which incorporated the intent and meaning of the House of Delegates actions. After thorough discussion, each statement was submitted to the Board of Trustees for approval and inclusion in the Policy Manual.

In accordance with direction from the Board of Trustees, the Policy Committee undertook the separation of the Policy Manual into "Administrative" and "Professional" sections. In the course of accomplishing this task, some duplication and inconsistencies were identified and eliminated. This year's manual is published in the new format.

More recently the Policy Committee has undertaken a detailed review of the relevance of some statements and obsolescence of others. When necessary, recommendations to the Board of Trustees will be made to up date the language of the policy or to submit resolutions to the House of Delegates for revisions of policy.

J. L. Bordenave, *Chairman*
David Fox Andrew Brislen

PUBLICATIONS COMMITTEE

The current 1973-74 fiscal year has been far from an idle one for the Society's Division of Publications. While the Publications Committee has concerned itself primarily with the *IMJ*, it has also provided parental guidance over many of the other projects of this Division, recommended and accomplished improvements in the print shop and established other long-range plans for further equipment additions to increase efficiency and capabilities.

Aside from *IMJ* responsibilities, the Division, through the print shop, has produced a remarkable number of other publications. A partial list of these includes: the MECO booklet listing all MECO positions, the "Insight" periodical of the Illinois Psychiatric Society as well as "Outlook," the periodical of the Illinois Ophthalmology Association. Others are the Monthly "Executive Memo" of the Medical Assistants, the booklet entitled "PSRO-The Law," and "Peer Review Guidelines." To list all of the items reproduced would belabor this issue. Suffice it to say that over 400 different jobs are produced annually, including such items for the members' personal use as the Statement of Understanding and HIC Forms. In 1973, over 2,100,000 press impressions were accomplished, equivalent to a small commercial shop, at a savings of perhaps 35% of commercial costs.

Illinois Medical Journal
Production and Costs

Among the new concerns for 1974 is the rapidly escalating cost of production and distribution. As you undoubtedly know, postal rates are to go up—first-class mail 20%, from 8¢ to 10¢; second-class, the method by which *IMJ* is circulated, will increase about 10%. Compounding this is the paper shortage. We can no longer purchase the paper stock which has been used—no one makes it any longer. We've had to go to a slightly heavier paper, by two pounds. This will increase mailing costs, based on pound weights, an additional 3½%. The crowning blow to this is that the paper companies, after discontinuing the line we used and forcing us to another stock, raised the price of the replacement item $1.50 per hundred weight.

However, even in the face of this difficulty and seeming adversity, costs of production for the *IMJ* have been maintained essentially the same—within a 2% variation level for the past three years. In fact, 1973 showed an expenditure only ½% more than 1972. This is attributed to several factors. First, among these would be good management and judicious application of all possible cost saving techniques. Second, a reappraisal of distribution of exchange and complimentary copies outside of Illinois has been made. This reduced not only issue costs but also postage. Third, while the number of articles and features included during the year was about the same as 1972, the total number of pages printed was 34 less in 1973. This reflected more efficient use of space available and improved editing and content review.

Advertising

A trend was reversed in 1973! Since 1967, each year has shown a decline in net advertising revenue compared to the previous year. But 1973 exceeded 1972. The increase was small, only about 1½%, but it is viewed optimistically as a harbinger of increased revenue in 1974. The true significance of this increase, however, is the comparison of *IMJ* status with other State Journals. Practically all suffered a sizable decrease in advertising and one journal has ceased publication. The January, 1974, issue reflected a 75% increase in ad pages and 56% in net income, compared to 1973. While one month does not foretell a year, the *Journal's* space representatives feel that the year during which they have been selling for us has allowed for the development of accounts we have not had heretofore.

While the slight 1973 increase did not offset the additional costs of doing business (the commissions of our space representing firm), it is conceivable that this may be accomplished this year. And an increased number of advertising pages will allow a greater number of editorial pages.

Looming large on the horizon, in considering future advertising by ethical manufacturers, are attempts at repeal of anti-substitution, brand name interchange legislation and generic prescribing. While the committee is not suggesting a particular stance on these issues, changes in the present laws could have a profound effect on advertising. This situation is being monitored closely.

Advertising rates were again reviewed, as done annually. In anticipation of cost increases in postage, paper and labor, a small increase of 5% in full-page black and white rates was effected. This was the first increase in this category in two years. Last year (1972) an increase in display and classified rates was implemented. The committee attempts to keep production and distribution costs totally covered by advertising net income. Rate increases must be made with caution, however, since *IMJ* page rates are extremely competitive with those of other state journals, only a few having a lower cost per page per thousand. Subscription rates also were increased slightly, to be more realistic.

Circulation

The year 1973 began with a circulation of about 12,470. Increased subscriptions and membership increases of about 700 members brought circulation up to 13,100 at the

close of the year. Subscribers increased by some 8%.

Presently *IMJ* is sent to every state in the Union, plus some 17 foreign countries. This is indicative of a wide utilization and acceptance of *IMJ* as a good source of information. To further illustrate this would be the annual tabulation of requests for copies of articles through Xerox University Microfilms, Ann Arbor, Michigan. This service has been available for three years and has been utilized with increasing frequency.

Content

In order to maintain balance within the *IMJ* a 2:2:1 ratio of advertising material, clinical/medical material, organization items is attempted. In 1973, this was maintained within a fairly close tolerance. However, advertising occupied only 37.8% of total pages.

It has been established that an average of 96 pages per issue should be met as essential to allow inclusion of all the items to be communicated to the members. This also was accomplished.

The report of the Editor gives further detail on content coverage. The Publications Committee has continued to review the content and has suggested some alterations in keeping with existing policies and to effect balance.

Tax Liability

As reported last year, agreement had been reached to settle a claim of tax liability with the IRS. Payment of some $2,500 was made to offset the assignment against 1967 advertising income. ISMS will file for a refund, plus interest, as soon as the statute of limitations runs out.

"Action Report"

Publishing "*Action Report*" is an intra-office cooperative venture. Editorial policy and time limits are demanding. Responsibility for its production is shared. Several Divisions cooperate, with Public Relations and Administration primarily accomplishing the writing or editing and the Publications Division doing all printing and distribution. In 1973, this report was circulated to some 4,100 persons regularly on a request basis. Twenty-one issues were thus distributed; five issues were sent to the full membership. All printing is accomplished in the ISMS office. While costs on this are relatively high due to its being mailed first-class, it has proved to be an effective communications tool to alert individuals to matters of immediate importance. Several proposals have been made to have each issue sent to all members. The Publications Committee has no specific objections to this; however, to accomplish this would cost nearly $35,000. Additional funding, therefore, would have to be provided before it could be done.

Publications Improvement

In addition to the activities reported above, several other items have helped to improve the Division's ability to produce more materials with a result in savings. Through the advertising monies set aside for publications improvement, two pieces of photographic equipment were obtained. Since hiring a photographer for an ISMS event costs $80 or more, two assignments will recover the cost of this equipment.

In addition, a heavy duty paper cutter was purchased for use in the print shop. In view of the paper shortage this allows purchase of odd lots, usually at reduced prices, which can be cut down. Also, padding and trimming which had been done outside is now done by staff, again with a resultant saving. The committee is soon to review a replacement folding and inserting machine to improve capabilities.

Other Activities

The committee is processing a new version of the *IMJ* "Policy Manual" to guide the operations of the editorial production staff. A new brochure on "Physician Recruitment" has been authorized to assist communities meet needs for a physician. Sales promotion items have been discussed and will be developed, particularly geared to local advertisers, to generate more ad space. Methods and ways of solicitation of local advertising, a project never pushed to any extent in the past, was also one of the Publications Committee's developments during 1973. Since 1974 is the Diamond Anniversary Year of *IMJ*, a special issue is planned for later in the year.

History Of Medicine

Two volumes on the History Of Medical Practice In Illinois have been published, Volume I in 1927 covering 1800 to 1850, and Volume II in 1955 reflecting the period 1850 to 1900. It has been proposed that Volume III, covering 1900 to 1950 or 1970 be published in conjunction with the U.S. Bicentennial in 1976. The Board has asked this committee to explore and develop proposals for this. To this end, a subcommittee of medical historians has been assembled to review possibilities and give direction. In addition, the Southern Illinois Medical School has offered staff support and co-sponsorship.

Conclusion

Publication-wise, this has been a year of continuous activity. Both routine and new objectives have been accomplished and the Committee is pleased to report on some of the successes. Is has been a pleasure to work with a willing, erudite and cooperative staff whose abilities often seem to know no bounds.

Jacob E. Reisch, *Chairman*

Warren W. Young — Frederick E. Weiss

Eugene T. Hoban — James A. McDonald

Editor of the *Illinois Medical Journal*

In its 74th year of publication, the *Illinois Medical Journal* continues to publish a wide scope of articles in areas of clinical medicine, continuing medical education and organized medicine.

"Pediatric Perplexities" was an added clinical feature this past year and "History of Medicine" offered another area of interest. This past fall, the Illinois Council on Continuing Medical Education expanded the "What Goes On" feature which is now "ISMS Guide to Continuing Medical Education," an extensive calendar listing of available continuing medical education courses.

Clinical medicine articles covered over 20 specialties. A breakdown of the editorial pages published during 1974 is a follows (minor articles not included):

Clinical Medicine:

Clinical articles	162 pages
Surgical Grand Rounds	28 pages
Pediatric Perplexities	14 pages
Maternal Death Study Case Reports	1 page
Medical Progress	35 pages
Trauma Center	26 pages
EKG of the Month	13 pages
View Box	11 pages
New Pharmaceutical Specialties	12 pages

Medically Related:

Medical Legal Review	13 pages
History of Medicine	6 pages
What Goes On/ISMS Guide to Continuing Medical Education	10 pages
Editorials	15 pages
Book Reviews	45 pages
Membership Forum	5 pages
Cooper Quiz	2 pages
Clinics for Crippled Children	6 pages

Organizational:

Abstracts of Board Actions	27 pages
President's Page	16 pages
Pulse of the Doctor's Wife	24 pages
AAMA Report	7 pages
Doctor's News	23 pages
Convention Delegates Handbook	62 pages
Convention Summary	14 pages
Legislative Report	4 pages
Reference Issue	107 pages
Physician Recruitment	28 pages

My sincere thanks and appreciation to the contributing editors: Drs. John M. Beal, surgery; Ruth A. Seeler, pediatrics; Harvey Kravitz, medical progress; Leon Love, radiology and John Tobin, cardiology.

I extend gratitude to the staff members who devote their time and skill producing the *IMJ*. It continues to be a pleasure serving as the Editor of the *Illinois Medical Journal*.

T. R. Van Dellen, *Editor*

Direct Reporting Committees

DRUGS AND THERAPEUTICS

The Committee on Drugs and Therapeutics met several times during the past year to refine the drug list contained in the Drug Manual of the Illinois Department of Public Aid. Countless hours were spent in reviewing physician's requests for drugs not listed in the manual in an effort to keep the Manual current and effective. The necessary deletions and additions were made.

At the present writing 3,000 written requests for drug usage have been received by the Committee. Numerous requests from pharmaceutical houses have been reviewed and action taken at their request, and submitted by this Committee to the Board of Trustees for their information and approval.

The Committee reviewed the correspondence from the National Pharmaceutical Council, Inc., regarding the resolutions of the Vermilion and Kane County Medical Societies. "This Committee recommends that we support and endorse the concept of brand interchange as outlined in the Vermilion and Kane County Medical Societies agreements. This has been our policy for the past two years."

A recent announcement by the government that it will limit payments for drugs needed by Medicare and Medicaid patients to the lowest cost at which the drugs are generally available, which usually would be the price charged for the "generic" version of a drug warrants a statement by this Committee. "The Committee feels that every patient is entitled to the best quality of medical care. The 'lowest cost listed drugs' is not a parameter by which to judge the quality or efficaciousness of the product. We are primarily concerned that each drug entity prescribed and dispensed to the patients are of the best quality and can assure us therapeutie response. There is no mention in the government's announcement on 'brand interchange'."

Sixteen drugs were approved for listing in the Manual for 1973. They are the following: Serentil, Geocillin, Antabuse, Doxychel (Vibramycin) automatie approval, Adapin (Doxepin HCl), Tranxene, Aarane and Aarane Inhaler, Intal, Polycillin PRB, Bactrim, Septra, Lithonate (Lithium Carbonate), SAS 500 (Azulfidine in Drug Manual), Hiprex, Tegretol, Remsed (tablets and syrup).

The Committee recommends to the Board of Trustees of ISMS that drugs approved by this committee for the "IDPA Drug Manual" be approved by them and given a number within 30 days of the mailing of an Action Report. The Trustees should obtain from the IDPA a computer number for each drug and publicize the dosage. This method would aid greatly in reducing the aggravation and the tremendous lag in time before the physician and pharmacist get notice of the approvals. Correcting this lag phase will tend towards better medical care.

The Committee appreciates the cooperation it has received from physicians as a whole. It welcomes their comments and will be guided by their sound therapeutic suggestions when making recommendations to the IDPA for future revisions of the Drug Manual.

Robert C. Muehrcke, *Chairman*

Richard L. Landau, *Vice Chairman* — William H. Walton
Joseph D. Cece — Andrew Krajec
Charles R. Frazer, Jr. — Arthur Marks

Consultants

Louis Gdalman, R.Ph. — Richard Suhs

INSURANCE COMMITTEE

During the past year, the Insurance Committee was quite involved in launching the new ISMS professional liability insurance program. Immediately following the Board of Trustees' approval of the program early in the year, the committee went to work on the mammoth task of switching the malpractice insurance coverage of several thousand doctors. Working closely with the committee, the new administrator, Johnson and Higgins, began a direct mail campaign to inform ISMS members that their professional liability coverage under the old

program would expire on May 31, 1973, and it would be necessary for them to make new applications in order to be insured by the Hartford Insurance Group.

By the time the new program went into effect on June 1, about 2,800 physicians were enrolled. The first year's participation goal was surpassed by the initial enrollment and as applications continued to be received, strong headway was made toward the second year's goal. However, by the end of the third year—July 1, 1976—it will be necessary to have 5,400 members in the program in order to have it succeed. For that reason, the committee urges all members to consider enrolling if they are not already participating in this program.

During the year, the administrator's representatives met with various physician groups to show a 15-minute sound-slide film describing the new program and to answer physician's questions about insurance. These representatives will continue to be available to any medical groups seeking information about professional liability.

According to its contract with the Hartford, ISMS is required to organize medical review committees in each district to screen all applications of physicians having a malpractice incident in the past five years and to review all claims under the program. In either case, underwriting or claims, the purpose of the review is to determine the medical standards of care involved in each incident and to advise the Hartford; about 10% of the applications require this screening.

J & H representatives met with the medical review chairman in each district to instruct him on procedures. This review is proceeding smoothly but slowly and it was necessary for the Hartford to provide interim coverage for many doctors whose applications were awaiting review. The Insurance Committee has provided back-up for the district committees by making judgments in questionable cases.

In addition to supervising the professional liability program, the Insurance Committee oversees these additional plans available to ISMS members: Group Life Insurance; Business Overhead Expense; Major Medical; Disability: Hospital Benefit; and Retirement Investment Programs.

Because of the complexity of the insurance business and its changing nature, the Insurance Committee has requested permission to retain a professional consultant to evaluate all ISMS programs and compare them to similar plans available to members through other medical organizations. The committee recognizes its obligation to offer ISMS members the most up-to-date insurance plans available and while it is constantly reviewing existing programs, the committee believes that periodic assessments by professional consultants can help make these programs more valuable.

Lawrence Knox, *Chairman*

Philip D. Boren — Martin Compton
A. Everett Joslyn — Theodore LeBoy
Charles W. Schlagater

Consultants

David S. Fox — A. Edward Livingston
Jacob E. Reisch — Fred Z. White

PHYSICIAN COMPETENCE COMMITTEE

A supplemental report will be submitted to the House of Delegates.

Thomas W. Stach, *Chairman*

William M. Lees, *Vice-Chairman* — Frank J. Jirka, Jr.
Willard C. Scrivner — George T. Wilkins
Fredric D. Lake — Marshall A. Falk

COMMITTEE ON REDISTRICTING AND TENURE

In light of the uncertainty surrounding the decision on PSRO area designations—which we believe to be of significance in considering redistricting—this committee did not meet during the past year. As soon as the U.S. Department of HEW has formalized its PSRO areas, the chairman will activate the committee.

In view of the interest of several county societies in redistricting—and what we consider valid reasons for wanting to redistrict—some mechanism must be developed to allow this to be accomplished as local needs might indicate.

J. M. Ingalls, *Chairman*
John Ring, *Vice-Chairman*

Julian Buser — Aaron B. Gerber
E. Newton DuPuy — Lawrence Hirsch
C. Larkin Flanagan — Wayne Leimbach
Jere E. Freidheim — Eugene T. Leonard

Consultants

Fredric D. Lake — Paul W. Sunderland
Warren D. Tuttle

COMMITTEE ON HEALTH CARE FINANCING

The Health Care Financing Committee was formed at the request of the Board of Trustees for the specific purpose of planning an educational program on socio-economic issues for presentation at ISMS' 1974 annual convention.

The Committee agreed that the three most significant socio-economic issues facing physicians today are: (1) health maintenance organizations, (2) ambulatory surgical treatment facilities, and (3) PSRO. The socio economic program, to be presented April 3, 1974, from 9 A.M. until 12 Noon, will discuss these topics and attempt to demonstrate how they affect practicing physicians.

Joseph R. O'Donnell, *Chairman*

Audley F. Connor, Jr. — Ronald Kelsey
Mack W. Hollowell — Herbert Natof
Robert T. Fox — Roy J. Philipp
Richard C. Schultz

Consultants

Mr. Leon Felson — Mr. Hilmon S. Sorey, Jr.

Ancillary Organizations

ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION

After the planning work of 1972—organization, staffing, selecting initial operational objectives—1973 saw ICCME move into high gear in pursuit of the purposes for which we were created:

1. The first Illinois Congress on Continuing Medical Education met April 19, 1973, attracting over 100 physicians (plus representatives of the Illinois Hospital Association and the Illinois Nurses Association)—the first assemblage of Illinois physicians to consider continuing education needs *from the physician's viewpoint.* Identifying ten desirable CME goals for Illinois, the Congress provided direction for future ICCME activities most closely related to the concerns of medical practitioners. The "Report" on that first Congress attracted wide attention outside Illinois, and over 200 copies were requested by medical schools, state and specialty societies, and other institutions over the nation.

The second Congress will focus on how to identify CME needs (a goal selected by last year's Congress), and will meet April 18, 1974, at the Oak Brook Hyatt House.

2. We published a unique handbook for physicians, *Your Personal Learning Plan.* Over 1000 Illinois practitioners have requested a free copy, and several clinics, hospitals, and county societies have requested bulk supplies for group distribution. In addition, several hundred MD's from other states have paid $1 each; one hospital (Gary Methodist) and two medical schools (Medical College of Ohio, Indiana University) outside Illinois have purchased quantities for distribution.

3. After careful analysis of other experience, a two-part CME calendar service was inaugurated: (a) a monthly calendar of CME activities in and near Illinois, for *Illinois Medical Journal,* and (b) arrangements for Illinois physicians to use the University of Wisconsin computer for individualized service.

4. By request of the ISMS Council on Education & Manpower, we developed a detailed CME accreditation system, and began to provide necessary staff work—including advice to hospitals and other medical organizations on how to meet ISMS criteria. As of December 31, 1973, four hospitals (plus ICCME) had been accredited, and another 15 hospitals and county societies were in varying stages of the CME accreditation process.

5. We developed a Logistics Map of Illinois physicians and health facilities.

6. We formulated a plan for CME workshops to be offered in 1974; in the process, we collected the first list ever compiled of Illinois hospital officers responsible for CME.

Planning for the Future

Perhaps more important than specific activities and services was our own growth as individuals and as the Board of this new Council, in two crucial respects:

First, early in 1973 we began to recognize (a) the shortcomings of traditional CME and (b) the enormous difficulties of devising new strategies attractive to sophisticated and busy professionals. On that basis, we initiated a self-education program to improve our competence to plan state-wide CME services.

Second, as our understanding of the problems grew, we adopted for 1974 an ambitious set of objectives:

1. A series of workshops on teaching-learning techniques for CME planners—hospital and specialty society officers responsible for physician professional education, and others interested.

2. Expand our counseling/consultation/information service for hospitals and other medical organizations, on effective CME methods and programs.

3. Develop a needs-analysis service for hospitals and other medical organizations (*e.g.,* assist in surveying MD interests).

4. Begin to publish a CME Planning Guide, a unique combination of learning theory and practical "how-to-do-it" advice for CME planners. Our aim is not merely to publish another textbook, but to reflect the best of practice in Illinois CME programs along with meaningful theory, in a loose-leaf format that will grow along with Illinois CME. This approach will invoke dozens of physicians, educators, and others as authors of various segments.

5. Investigate methods of evaluating CME effectiveness —a major goal identified by 1973 Congress participants, and one of the most difficult problems in CME.

6. Plan a major study of the learning habits and interests of Illinois physicians. Only one such study has previously been done (in Michigan); we hope to build on that achievement to produce major research findings of national importance.

7. Investigate possibility of a "Visiting Professor" program, under which scholars and other medical experts would spend full days at interested Illinois hospitals, consulting with local staff, conducting bedside and grand rounds, lecturing on recent research, *etc.*

8. Plan a mini-residency program so that individual physicians might spend brief periods (5 to 30 days) at major medical centers for intensive learning experiences in subject areas of their choice.

9. At the request of ISMS, develop leadership training for officers and other leaders of the State Society, county societies, hospitals, and other medical organizations.

In summary . . . 1973 saw ICCME well on its way to becoming a powerful agent in service to Illinois medicine.

Dean Bordeaux, *President*

Edward W. Cannady, *Vice-President*
Robert Fox, *Secretary*
Eli Borkon, *Treasurer*
J. Ernest Breed
Herschel Browns
Joel Brumlik
Willard G. DeYoung
John Graettinger
Henri Havdala
Chase P. Kimball
Boyd McCracken
George E. Miller
Ward Perrin
Mather Pfeiffenberger
George Shropshear
Jacob R. Suker

PRESIDENT OF THE WOMAN'S AUXILIARY

It has been called "a transitional year," making apropos in many respects our theme, "To the Stars Through Aspirations." We've risen above the mundane and sometimes negative aspects, overcome some reversals and consummated the conversion of attitudes, goals and work habits into a visionary and meaningful working body.

Co-sponsorship of the Health Education Symposium with the Illinois State Medical Society stimulated interest and activity throughout the state. Our fall combined district meetings, held in Belleville, Springfield and Chicago, stressed Health Education, and the stimulus of professional speakers and idea exchanges, resulted in attendance of over 200 Auxilians. District Councilors, working with the vice-president responsible for community health activities, reported on health services available in organized counties and counties where there are members-at-large. We now have before us, as the result of this Project "Search," a picture of health care facilities available in 28 counties. Further work is to be carried out on this project.

Communication was successfully promoted throughout the year. The President corresponded with Board members and County Presidents monthly, enclosing Auxiliary pages from the *Illinois Medical Journal*. A summer Board meeting enabled the President to share materials and information from the National Convention with Board members promptly. All chairmen communicated effectively with county chairmen, and District Councilors assumed their responsibilities in working with their counties most efficiently.

The promotion of membership is a constant challenge, and our "Acting" President-Elect and Membership Chairman has devised innovative ways to increase membership. The membership goal is 500 new and re-instated members, and we are well on our way to reaching that goal through promotion of the challenge of EMGM—Every Member Get a Member.

Legislative activities were promoted in mailings to 24 county legislative chairmen. Legislative kits were mailed to 11 county chairmen.

Our Public Affairs Chairman presented explanation of, and distributed, "Key Woman Kits" at District Meetings and actuated participation for the Washington Roundup and the Public Affairs Breakfast at the Annual Convention.

The Press and Publicity Chairman has been stimulating counties to submit reports of activities, which keeps our Editor informed of major Board activities.

On opposite ends of the scale are our activities in regard to Children and Youth, and the Aging and Homebound. We are represented by a delegate and alternate on the Illinois Commission on Children composed of members of statewide cooperating organizations and other contacts relating to the White House Conference on Children. The development of a child's potential, all aspects affecting the growth and development of children, childrens rights, as well as the drug problem, sex education and venereal disease, are considerations.

The Aging and Homebound committees are providing services for Doorbell Dinners for the Homebound, providing clothing and bed restraints for nursing homes, as well as recreational activities for the residents. One county is providing and training volunteers for work with the aging.

The picture of Mental Health has changed; since mental health centers provide for many of the needs of the communities, several counties report having crisis phone lines, aftercare programs, drug education and worry-go-rounds.

Concern for Safety is an on-going and increasingly important project, whether it is the promotion of home safety, automobile safety, safety in sports, etc. The Auxiliary will participate in an all-state safety project this spring and summer by means of the distribution of a plaque on mouth-to-mouth resuscitation to be used at the site of home, public and club swimming pools throughout Illinois. Counties will be encouraged to purchase these plaques and donate, or sell them at a very nominal cost within the communities.

Two Illinois Medical Schools in Illinois have WA/SAMA chapters; we are continually endeavoring to organize others. Prospective chapters may develop in Springfield and Rockford.

The sale of merchandise for the benefit of AMA-ERF is actively undertaken; however, at this writing, it would not be accurate to state amounts earned. We are very gratified, however, that we can be recognized as Project Credit contributors as a result of our joint giving with the Illinois State Medical Society.

Our Benevolence contributions are noteworthy, and counties feel a very real sense of satisfaction in participating.

Convention promises to be informative and entertaining. Mrs. Willard C. Scrivner, WA/AMA President, has placed emphasis on safety, aging and homebound, and the problem of child abuse. We will have speakers on these subjects, as well as an inspirational keynote speaker. Mrs. Joseph Kerwin, wife of physician-astronaut Capt. Joseph Kerwin, who was honored at the Illinois State Medical Society's Leadership Conference, will also participate in our program. Thursday, April 4, will be Presidents Day, honoring our national president, past presidents and county presidents.

A Committee on Committees has been studying our Board structure and has made recommendations to the Revisions Committee for stream-lining our Board, when our Bylaws undergo revision in 1975. Economy, efficiency and effectiveness prompted our survey. Amendments were proposed and approved which will make our operation more flexible.

I have taken advantage of every opportunity for learning, and have endeavored to share experience with the membership. This past year I attended the Indiana, Ohio and Kentucky State Conventions, the American Medical Association Auxiliary Convention as presidential delegate, a Communications Symposium, all district meetings, the national Fall Conference for presidents and presidents-elect, the Regional Workshop, the Illinois State Medical Society Leadership Conference, Health Education Symposium, all committee meetings with the exception of the nominating committee, the Illinois Commission on Children meeting in January, the Washington Roundup, and visited county auxiliaries, as requested.

Hopefully, the transition has been made in guiding the Auxiliary toward deliberation in thought and action, in the awareness of better ways of work and responsibility for carrying them to fruition, and in the direction of new horizons with dedication and enthusiasm.

Mrs. Robert (Beatrice) Hartman
WA/ISMS President

ILLINOIS SOCIETY, AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

The Illinois Society of the American Association of Medical Assistants has devoted its efforts to projects and programs that provide information which will enable the Medical Assistant to become a more effective and productive member of the "health care team." This activity would not have been possible without the able assistance of many dedicated members and the invaluable support of the Illinois State Medical Society.

The Illinois Society, by the end of April, will have conducted the following conferences and educational programs: nine traveling courses with malpractice, laboratory procedures and Medicare the sole topics; 13 governmental workshops, co-sponsored by the Illinois State Medical Society, with detailed discussions and distribution of information folders on Medicaid (Public Aid), Medicare and CHAMPUS; a day-long session at the ISMS Annual Meeting and the Midwest Clinical Conference with presentations on public relations, medical ethics, credit and collection and office safety; and, a day-long symposium on Professional Liability and related medical-legal matters. In addition to the conferences and educational program, the Society will devote one and one-half days to educational and informational sessions at our Annual Meeting.

The Illinois Society currently has 27 active local chapters and new chapters are being established in Boone County, Aurora, Coles and Cumberland Counties, Saline, Pope and Hardin Counties and in southwest Cook County. Our established and developing chapters have actively worked to make available educational and informational meetings throughout the year. As with the Illinois State Medical Society, the real success of our organization is dependent on the activity and interest of persons at the local level.

Doctors, if your area has a local chapter, please see that your assistants, whether they be nurses, secretaries, technicians, bookkeepers or receptionists, become active members. If your area does not have a chapter, we will be happy to furnish information and provide assistance in developing a local chapter. Any inquiries of this nature may be addressed to the Public Relations Department of the Illinois State Medical Society.

Through the Society's affiliation with the American Association of Medical Assistants we are able to take advantage of their many worthwhile programs. Of particular interest to the Medical Assistant and the physicians of Illinois is the Certified Medical Assistant Program and the Certification of Medical Assistant Training Programs at the college level. The Certified Medical Assistant Program provides the opportunity for a Medical Assistant, after meeting all basic requirements and successful completion of a rigid examination, to demonstrate to the physician employer his/her competence. The accreditation of college level programs leading to a certificate or diploma in medical assisting provides assurances that the student will obtain an education that is appropriate and useful in the medical office. Several colleges and universities, interested in developing medical assisting programs, have been furnished information on the course content and other requirements of this certification.

On behalf of the AAMA Illinois Society, I would like to thank Willard Scrivner, M.D., ISMS President, William Lees, M.D., ISMS Chairman of the Board of Trustees, the Board of Trustees, Mr. Roger White, and the Headquarters staff, especially the Public Relations Department. In addition, our thanks to Carl Clark, M.D., our ISMS liaison, and our other physician advisors, Allison Burdick, Sr., M.D., Thomas Harwood, M.D., William Sheehy, M.D., Peter Soto, M.D. and John Wright, M.D.

We look forward to continuing support of the Illinois State Medical Society and trust that we will be able to be of greater assistance to the Society and its members.

Norma Domanic, LPN
President

STUDENT LOAN FUND BOARD

During 1973 there were major changes in the operation of the Student Loan Fund Program, which has been jointly sponsored by the ISMS and the Illinois Agricultural Association since 1948.

First, it was necessary to establish a line of credit with the Country Life Insurance Co. in order to make any new loans because the fund had become overextended. This situation arose because it takes nine years for a student to complete repayment of loans that he started to take out as a freshman, and because the Loan Fund Board has felt obligated to make loans to those students who are admitted to the University of Illinois on a recommendation of the board. There have been many more students accepted in recent years than there were in the early days of the program.

In any case, the new arrangement is working well and the fund has been stabilized so that $15,000 per year can be allocated to each class for student loans. While first preference for financial aid is offered to students that receive recommendations to the University of Illinois, students at other medical schools may be granted loans from the fund if the $15,000 is not utilized.

During the year, the First National Bank of Chicago, which has acted as trustee of the fund since its inception, notified the Board that it would prefer to relinquish the account and arrangements were made to transfer the fund to the IAA Trust Co. in Bloomington. This was accomplished on September 1, 1973, when the IAA Trust became "custodian" for handling notes, contracts and agreements and making the loans.

This new arrangement made it necessary to establish a more formal relationship between IAA and ISMS for operating the fund. Therefore, ISMS entered into a legal partnership with IAA to conduct a business for making low-cost loans to medical students who promise to practice medicine in rural Illinois. The business will continue to be operated by the Medical Student Loan Fund Board, which has equal representation from the sponsoring organizations.

The program evaluation completed by Dr. Dale Mattson, former admissions director for the University of Illinois at the Medical Center, demonstrated that the program has been effective in placing doctors in rural areas. As the University of Illinois College of Medicine has increased the size of its freshman class, the number of students on the Medical Student Loan Fund Program has also increased. In 1971, there were 11 new students: in 1972 there were 24 new students; and in 1973, there were 31 new students accepted.

Donald Stehr, *Chairman*

Jack Gibbs — Charles Salesman

EDUCATIONAL AND SCIENTIFIC FOUNDATION

The Educational and Scientific Foundation of ISMS was established in 1961. The Foundation is incorporated in Illinois and financial support is tax-deductible. It is dedicated to the advancement of medical knowledge and the education of the public, particularly in the State of Illinois.

A Board of Directors, that consists of the ISMS president, president-elect, immediate past president, secretary-treasurer and the chairman of the Board of Trustees manages the Foundation. The immediate past president serves as chairman of the foundation board and the secretary-treasurer of the society occupies the same post in the foundation. The classes of membership in the foundation are:

1. Fellows of the Foundation are physicians holding regular membership in the foundation following the contribution of $100 or more.

2. Associate fellows are non-physicians holding regular memberships in the foundation following a contribution of $100 or more.

3. Honorary fellows are individuals whom the foundation's Board of Directors elect to membership because of their exceptional service to the organization and its goals.

During the year, the foundation took the following actions:

a. Allocated from unmet medical needs:

1. $4,000 contribution to ASPIRA, meeting the 1973 provision for a further contribution.

2. $4,000 contribution to Council on Bio-Medical Careers, fulfilling the 1973 provision for a further contribution.

3. Approved a request from the Illinois Foundation for Medical Care for a line of credit of $40,000 for a period of three years with the provision that the loan may be renewed after that time. As of this writing, $10,000 has been used and interest has been paid for 1973.

4. The Interstate Postgraduate Medical Association of North America contributed $5,000 grant to the foundation; and in turn the foundation granted the funds to ICCME for the *Your Personal Learning Plan.*

The foundation received $3,000 from Merck Sharp & Dohme for operation of the Scientific Speakers Bureau in 1972. During the year, expenses and honoraria were paid to 35 speakers addressing medical societities in the following counties: Coles-Cumberland, Clay, DeKalb, Jefferson-Hamilton, Knox, LaSalle, Livingston, Macoupin, Montgomery, Peoria, Vermilion, Wabash, Wayne, White, Whiteside.

Frank J. Jirka, Jr., *Chairman*

Fredric D. Lake — Jacob E. Reisch

William M. Lees — Willard C. Scrivner

Affiliate Societies

COUNCIL ON AFFILIATE SOCIETIES

The Council on Affiliate Societies, created last year at the direction of the House of Delegates, was activated September 19, 1973 to: improve liaison between ISMS and specialty societies; provide consultation to other ISMS councils and committees; and serve as a resource unit on medical advances in specialty fields.

At its initial meeting, the council developed a priority list of projects on which it plans to concentrate its efforts. Its chief priorities include:

- Legislation—Enlisting the support and coordinating the efforts of specialty societies in legislative programs. This, of course, includes review of proposed regulations affecting the medical practice of all physicians.
- PSRO—Enlisting specialty society assistance in developing minimum standards for medical care contingent upon ISMS' involvement in PSRO.
- Relative Value Study—Assisting in development of the proposed update of the ISMS Relative Value Study.

The Council devoted its next two meetings to the study and redrafting of proposed licensing requirements for Ambulatory Surgical Treatment Centers (ASTC), which will be considered by the ASTC Licensing Board in late February or March. In its recommendations to the ASTC Board, the Council urged:

1. ASTC staff privileges be broadened to include "any physician licensed to practice medicine in all its branches & qualified to perform surgical or medical procedures based on his training, experience & demonstrated ability." (The proposed regulations would restrict ASTC privileges only to board certified specialists.)
2. ASTCs be required to appoint a credentials committee from its medical staff to establish privileges for staff physicians. (Proposed regulations have no such provision).
3. ASTCs be required to have the necessary equipment and trained personnel available for cardiac pulmonary resuscitation.
4. Deletion of requirement that ASTCs have a formal transfer agreement with a hospital not more than 15 minutes from the facility. The Council believes it is sufficient for ASTC staff members to have admitting privileges in a nearby hospital.

These recommendations were among the many made to IDPH and the ASTC Licensing Board.

Samuel Cloninger, *Chairman*

Robert Bettasso
Lawrence Breslow
Edward Brunner
William B. Buckingham
James Burden
Norman M. Frank
Jack Gibbs
David Helberg
William R. Malony
Robert C. Muehrcke
George Pollock
Simon Ramah
Bill B. Smiley
E. B. Sylvester

Economics and Peer Review

COUNCIL ON ECONOMICS & PEER REVIEW

The Council on Economics & Peer Review was increasingly active during the past year and considered many socio-economic issues facing Illinois physicians. The Council also continued to serve as the state appellate mechanism for peer review of cases initially considered by county or district peer review committees. This function was delegated to a Peer Review Appeals Committee comprised of Council members.

In addition, the Council served as ISMS' liaison with the health insurance industry, government health programs and the Comprehensive Health Planning program. There was increased activity in improving relations between ISMS and the various CHP "b" agencies throughout the state.

Major activities highlighting the Council's efforts during the year included:

- studying the feasibility of revising an Illinois Relative Value Study and, through a special RVS Committee, make specific recommendations to the Board of Trustees for producting a new Illinois RVS **(Resolution 73M-22)**;
- requesting insurance carriers, including Illinois Blue Shield, to release fee information to state and county peer review committees **(Resolution 73M-11)**;
- considering the development of model health insurance policies as per **Resolution 73M-9,** and recommended that the Illinois Foundation for Medical Care provide the expertise necessary to draft a model policy;
- developing guidelines for health insurance carriers outlining conditions that should be met before a case could be submitted to peer review;
- exploring the feasibility of a single billing form for patients on Medicare and Medicaid, **Resoution 73M-6**;
- It was determined a single billing form would not be feasible because of different administration, funding sources and payment levels;
- calling on all health insurance carriers to pay for assistant surgeon and consultant services **(Resolution 73M-12)**;
- meetings with health insurance representatives to resolve issues regarding release of medical information and the completing of claim forms **(Resolution 73M-18)**;
- conferring with Medicare carriers to rectify the arbitrary disallowance of claims and clarify the role of diagnostic procedures and tests in providing quality medical care **(Resolution 73M-20)**;
- requesting endorsement of a position clarifying the role of the assistant surgeon in hospitals and the propriety of surgical assistance when house staff is available;
- requesting ISMS approve the principle of payment to physicians serving on utilization review committees;
- asking the Board of Trustees to formally express its displeasure to the Illinois Department of Public Aid for its poor payment practices and slow claims processing; and
- working to incorporate ISMS' amendments into pending Illinois HMO legislation.

The Council was again responsible for a government health workshop program for medical assistants. Approximately 750 medical assistants attended workshop sessions in various areas of the state. Representatives from Medicare, Medicaid and CHAMPUS (Civilian Health & Medical Program of the Uniformed Services) conducted these workshops.

Peer Review Appeals Committee

The Peer Review Appeals Committee, comprised of members of the Council on Economics & Peer Review, considered nine cases during the year. These issues, appealed by physicians, patients or third party payors, had previously been considered by local county medical society peer review committees.

The Committee also drafted guidelines for insurance carriers to follow before submitting a case for peer review.

Special Relative Value Study Committee

The Special RVS Committee was formed to study the feasibility of updating the Illinois relative value study. It made specific recommendations to the ISMS' Board of Trustees for producing a new Illinois RVS. The recommendations included using AMA's CURRENT PROCEDUAL TERMINOLOGY, third edition, as the code for the relative value study, and asking cooperation from all specialty societies in preparing the RVS.

Council

Fred A. Tworoger, *Chairman*
Robert J. Becker, *Vice-Chairman* — Earl E. Fredrick, Jr.
Charles E. Baldree, Jr. — R. Gregory Green
Alfred Clementi — A. Beaumont Johnson
Edward DuVivier — Henry P. Russe
John L. Eaton — Maynard I. Shapiro
Joseph Silverstein
Ronald T. Staubly, Intern-Resident Member

Consultants

David Fox — Joseph R. O'Donnell
Eugene P. Johnson — Frederick E. Weiss
Frank J. Jirka, Jr. — Wayne Domin, *SAMA*

Peer Review Appeals Committee

Robert J. Becker, *Chairman*
Edward DuVivier — Earl E. Fredrick, Jr.
John L. Eaton — Henry P. Russe

Special Relative Value Study Committee

Robert J. Becker, *Chairman*
Joseph L. D'Silva — Clifton L. Reeder
Theodore Grevas — Ben Williams

Consultant

Jacob E. Reisch

ILLINOIS DEPARTMENT OF PUBLIC AID

In October, 1973, 1,069,846 Illinois residents received some type of public assistance. Expenditures were more than $128 million for the month.

During October, 1,016,135 received medical assistance at a cost of nearly $51 million. Hospitalization accounted for $17.9 million; group care, $12.7 million; physicians, 6.9 million; drugs, $6.0 million; and clinic out-patient payments, $3.2 million.

The Medical Assistance appropriation for Fiscal Year 1974 was $581.2 million, or 40.51% of the total $1.4 billion public aid appropriation.

Legislative action, both state and federal, had a major impact on Illinois Department of Public Aid programs in the latter part of 1973.

State legislation signed into law in late August permitted the department to formulate an entirely new system of assistance grants for families with dependent children. For more than 30 years, the department had a highly complex system for figuring the amount of assistance a family received. Grants were based on the number and ages of children in the family. Additionally, the department provided up to 90 special allowances which were given on the basis of individual circumstances.

On October 1, 1973, the department adopted a Consolidated Standard Plan—or flat grant—for Aid to Families with Dependent Children (AFDC). Payments vary by family composition and housing costs. Some special allowances are retained.

The Medical Assistance program for AFDC families remains unchanged. Some medically related allowances previously paid as part of the assistance grant are now being provided through the Medical Assistance program. These include prescription diet supplements, prosthetic appliances, and transportation to the source of medical care if the provider will accept direct payment from the department.

The new system is more equitable and eliminated much of the built-in possibility for error of the old system.

The Social Security Amendments of 1972, which federalized assistance programs for the aged, blind and disabled, became effective January 1, 1974. Under the new law, the Social Security Administration assumed responsibility for administration of a basic cash payment to needy aged, blind, or disabled persons with limited assets. The nationally standardized grants of $140 for an individual, and $210 for a couple, are not at a level equal to grants received by most Illinois welfare recipients prior to January. Amendments to the law required states like Illinois to supplement the federal grant so no person would suffer a loss in benefits due to conversion from the switch to federal program. Senate Bill 16, signed on December 20. 1973, provides for possible state supplementation of grants for persons who become eligible for the new Supplemental Security Income program (SSI) after January 1. The department also is continuing to provide necessary medical services, food stamps and social services.

It is estimated that 120,000 additional Illinois residents will be eligible for SSI within 12 to 18 months. Many also will be newly eligible for the state's Medical Assistance program. For all practical purposes, the department's traditional responsibility for needy aged, blind, or disabled persons will continue to expand. The impact of SSI on Medical Assistance is not known, but it is a matter of concern.

Illinois Senate Bill 900, also signed in late August, authorizes the department to contract with and make advance payments to public or private health care and rehabilitative organizations for the provision of medical services to public aid recipients. This bill enables the department to enter into contractual agreements with Health Maintenance Organizations (HMOs), special MEDICHEK projects and similar organizations, in order to open up more medical services for poor people.

One of the main areas of complaint on the part of providers of medical services concerns the involved paperwork, inadequate payments for services, and delays in payment. This would be overcome in a prepaid arrangement since claim forms would be eliminated and cost negotiated in advance.

New HMO guidelines have been written by the Comprehensive Health Planning Agency and are available through that agency.

MEDICHEK, the preventive medical program administered jointly by the Illinois Departments of Public Aid and Public Health, implemented in February, 1972, for children from birth through five years was expanded July 1, 1973. The program now provides diagnostic tests, immunizations, medical and dental check-ups and treatment for public aid-eligible children and youths to age 21. The first nine months of calendar 1973, 15,000 examinations were completed through this federally-mandated program.

At the end of 1973, five vendor agencies had contracted with IDPA to provide MEDICHEK services. They are: Winnebago County Department of Public Health, Rockford; Rock Island Health Council, Inc., Rock Island; Robert S. Mendelsohn, M.D. Professional Corporation, Chicago; Westown Health Center, Chicago; and the East Side Health Center, East St. Louis. Additionally, plans are being finalized for the establishment of a MEDICHEK representative in each county and district public aid office.

Joel Edelman, J.D.
Director

Visit the Exhibits

Education and Manpower

COUNCIL ON EDUCATION AND MANPOWER

The Council on Education and Manpower has concerned itself with a wide range of activities within the fields of medical and allied health education, medical and paramedical manpower, liaison with medical schools, student and house staff activities, and governmental agency activities.

Action on 1973 Resolutions

Resolution 73M-5, adopted by the 1973 House of Delegates, called for the Council to prepare and implement an accreditation system for continuing medical education programs offered in Illinois. A summary of this program can be found under the subcommittee on accreditation.

Resolution 74M-33 called in part for an accounting of funds spent from the dues allocation also authorized under 73M-33. This accounting is not available at this time and will be furnished to the House as a supplementary report from the Council on Education and Manpower.

Rural Health

A member of the Council served as the ISMS representative to the AMA Congress on Rural Heatlh. As a result of the recommendation of this representative, the Council recommended to the Board of Trustees that a committee on rural health be formed under the Council on Social and Medical Services. The Board approved the spirit of the recommendation and expanded the role of the existing Committee on Health Care of the Poor to include rural health problems.

Hamilton Teaching Award

Each year the Edwin S. Hamilton Interstate Teaching Award is presented to an outstanding Illinois medical educator. The Council on Education and Manpower nominates and elects the recipient, at the request of the Interstate Postgraduate Medical Association of North America. The award, named in honor of ISMS Past-President, Edwin S. Hamilton, will be awarded in 1974 to Harold A. Sofield, M.D., Professor Emeritus of Orthopaedics at Northwestern University Medical School.

Liaison With Council of Deans

The liaison committee formed to maintain close communications with the Council of Deans has not been active this year. All attempts on the part of the committee met with apathy from the Deans, and as a result the hoped for communication has never been established.

Legislation

Senate Bill 501, introduced by Senator Soper, created a "fifth pathway" for the licensure of Illinois residents who are graduates of foreign medical schools. This bill was amended at the request of ISMS and was passed by the legislature. The bill was enacted into law in spite of the Governor's veto in October of 1973, and became law in January, 1974. The bill potentially affects all Illinois Schools, and therefore is being carefully watched by the Council.

Accreditation

The Subcommittee on Accreditation was formed from the Council to implement a program of accreditation for the groups and institutions offering continuing medical education in Illinois. The final program involves the Illinois Council on Continuing Medical Education, who performs the actual site evaluation, with the Subcommittee reviewing the site data and making the final decision on accreditation.

To date five institutions have been evaluated and accreditation granted. These institutions will be recognized during the Annual Meeting.

Manpower Subcommittee

The Manpower Subcommittee is in process of gathering materials on the various emerging paramedical and ancillary health careers including physicians assistants and the various categories of nurse assistants and nurse practitioners. In addition, this subcommittee is compiling information to be used in the event of legislation intended to establish licensure requirements for any of these professions.

Advisory Committee to Medical Students and Physicians in Training

The most significant activity of the Advisory Committee to Medical Students and Physicians in Training, during the past year, has been the involvment of interns and residents in some of the affairs of the medical society.

Under the special prodding of two active residents the committee made contact with several house staff organizations, holding two meetings with representatives of local hospital house staff associations, and has made general mailings to interns and residents in the state in an attempt to solicit interest.

Eventually, it became apparent that the only interns and residents who were really interested in becoming involved in medical society activities were those who had already joined ISMS for one reason or another. These, then were invited to a dinner meeting at which William Lees, M.D., Chairman of the Board of Trustees, explained the structure of the society, discussed some of the current concerns of organized medicine, and issued an invitation for those present to become members of ISMS councils. Although medical students have been members of ISMS councils and committees for several years, it was not until 1973 that interns and residents were appointed members.

Using these intern-resident members as a nucleus for increasing liaison between ISMS and the house staff

physicians of Illinois, an attempt is being made to discover not only the interests of the young physician, but also the projects on which he is working that ISMS as a whole might support. The search is beginning to be successful as a handful of requests for financial and moral support have been received from different groups of students and house staff physicians needing equipment in clinics or support for programs. Approval of these requests is pending.

Another avenue for liaison is through an annual meeting program being planned around "Issues Involving House Staff." The relationship of the AMA's Intern-Resident Business Session, the AMA's House Staff Committee, the Physician's National House Staff Association, as well as other house staff interests, will be explored in a panel discussion. The program should be of interest to all ISMS—not only those still in training.

In 1973, ISMS for the first time sent two residents to the AMA annual meeting in New York and the clinical convention in Anaheim. ISMS representatives were Drs. Bruce Fagel and Kong-Meng Tan. As it has for the past several years, ISMS also sent two medical students to these AMA conventions, with Jeff Waitzman and Bill Yasnoff attending the New York meeting, and Michael Hughey and Boyd McCracken attending the Anaheim meeting. In addition to participating in those sessions particularly set up for them, the residents and the students took part in reference committee hearings and attended all meetings of the regular ISMS delegation to the AMA.

As house staff physicians become more involved in ISMS affairs, it is becoming apparent that their interests are quite distinct from those of medical students, and it has been recommended that the Advisory Committee be split into two—one for medical students and one for interns and residents—both reporting to the Council on Education and Manpower.

On March 11-12, ISMS will co-sponsor an AMA practice management workshop for new physicians. Entitled "Establishing Yourself in Medical Practice," the workshop at the Sheraton-Chicago covers personnel problems, patient flow techniques, clinical and financial paperwork and legal problems.

Fifty-one hospitals will participate in the 1974 Medical Education-Community Orientation (MECO) program. This is down slightly from the 56 participating hospitals last year and means that there will again be many more student applicants than there are places to assign them. Since this program started in 1969, 600 students have taken part in the program in this state. Started in Illinois, it is now a nation-wide program supervised by the national office of the Student American Medical Association. This office is now trying to locate the present location of every student who has gone though the program in order to release statistics on the correlation, if any, between the MECO location and the residency or practice location.

Another project of the Advisory Committee is just getting under way; it is a combined senior elective bulletin which, hopefully, will list all those out-of-school electives approved by the medical schools of Illinois.

While the Advisory Committee to Medical Students and Physicians in Training has been very busy, it is recognized that the total number of student members and in-training members of ISMS is still small. Recruitment efforts are being planned for both classes of membership, although there are still barriers that need to be removed. Although the ISMS bylaws technically provided for student memberships, it was not until 1973 that it actually enrolled any because most county medical societies did not provide for them previously. Now it is hoped that the House of Delegates will remove from the bylaws a requirement that a candidate for *student* membership must first be a member of SAMA and that through a cooperative effort by the Chicago Medical Society, ISMS and the AMA the total student dues can be decreased. Presently a student must pay $10 to the county society, $10 to ISMS and $15 to the AMA. Most students consider the total to be too high and have suggested a one-time dues payment rather than an annual assessment.

The SAMA delegate to the 1974 House of Delegates will be Jeff Waitzman, a University of Illinois senior; alternate will be Bill Yasnoff, a Northwestern sophomore.

Council

Morgan Meyer, *Chairman*
Allison Burdick, Jr., *Vice-Chairman*

J. Ernest Breed — Lawrence Hirsch
Herschel Browns — Donald Stehr
George O. Dohrmann — Jeff Waitzman, *SAMA*
Jack L. Gibbs — Michael Hughey, *SAMA*
John Holland — Bruce Fagel, *I/R*
David Spindel, *I/R*

Consultants

Robert T. Fox — Allan L. Goslin
Fred Z. White

Committee on Manpower

Donald Stehr, *Chairman*

William Durham — Charles R. Frazer
Roger Hendricks

Consultants

George Shropshear — Kermit Mehlinger
Allan Goslin — Michael Hughey, *SAMA*

Committee on Accreditation

Herschel L. Browns, *Chairman*

George Dohrmann — John Huss
Jack Gibbs — L. P. Johnson
Ross Hutchison — Rex McMorris

Advisory Committee to Medical Students and Physicians In Training

Allison Burdick, Jr., *Chairman*

Gerald Berkowitz, *Vice Chairman* — Eli Borkon
Carl Barthelemy — Richard Locke
Arthur Appleyard, D.O. — John J. Taraska

ILLINOIS DEPARTMENT OF REGISTRATION AND EDUCATION

Early in the Walker Administration a mandate was given on delivery of health care services; we in the Department of Registration and Education have accepted the challenge for revitalized regulatory processes in that interest. The smooth flow of the licensure-renewal-inspection-investigation-enforcement function is relatively the same for all 32 professions and occupations regulated by DRE; but, perhaps at this time none is as signficant as for those registrants in the health professions. In 1973, DRE made several important changes for improvements.

Internal Management

The position of Superintendent of Registration was instituted once again, and a restructuring in organization of the licensure sections was immediately implemented to align similar types together for closer management. The health professions sections share physical proximity within DRE offices, as well.

Medical Section

The Medical Section, always one of DRE's busiest, has grown from three clerk-stenographers, under its Supervisor, to five, with an additional temporary position established to assist with high volume. One person has been assigned the handling of requests for licensure vertification, which at times of necessity have been left unattended for extensive periods. Illinois is one of the few remaining states which examines candidates from other states as a courtesy, which contributes to the workload.

Temporary authorization for full practice has been streamlined so that after the filing of an acceptable reciprocity application it can be issued without the need of reporting for interview or examination. DRE considers this a successful expansion of the law, with few problem cases.

The Medical Section helps better serve the Illinois Medical Examining Committee by an informational letter sending to most major teaching hospitals and schools with our examination schedule, reminder of filing deadlines, and a supply of questionnaires. Applications sent in with proper information at the outset can be channeled more easily. A new time-saving service for staff and registrants is the listing of new registrants sent to officials issuing narcotic permits, alleviating the delay in answering separate license verifications. This Section also assisted the Illinois State Medical Society again with the Doctor's Job Fair by supplying lists of candidates.

Electronic Data Processing

Electronic Data Processing, essential to progressive state service, is steadily achieving its potential in DRE. New staff assigned to correct some early problems in the programming accomplished their goal in 1973, bringing the systems up to date for speed and efficiency. Statistics for Fiscal Year 1973 as reported by EDP are as follows:

	Original	Renewal
Physician	1,784	22,752
Osteopath	0	88
Chiropractor	41	1,000
Drugless Practitioner	0	34
Midwife	0	4
Osteopath-Obstetrician	0	97
State Hospital Permit	45	245

Total number of registrants in good standing under the Illinois Medical Practice Act was 26,090. Total number of all registrants was 427,340.

Enforcement

Enforcement, too, has received a full measure of attention. Subject to public and/or professional criticism on occasion, it is in fact one of the most difficult functions in the agency. Inspections do not always reveal violations or problems which actually exist; complaints must be cautiously investigated to protect both the physician and the complainant with sensitivity to each situation.

The "Sick Physician" provision of Paragraph 6, Section 16a of the Medical Practice Act, for example, is one such controversial issue. DRE attorneys have defined habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance of professional duties as grounds for revocation, and while action requires formidable burden of proof, we are presently studying cases in other states as precedence. Formal hearings for revocation are extreme, but it has been the agency's position and continues to be that complaints in this area will be investigated; failing results from informal hearings, formal prosecutions will be undertaken.

Similarly, there are problems with regard to physicians who prescribe narcotics and dangerous drugs unprofessionally. Two formal complaints were recently initiated, though legal staff of DRE believe the law is weak with respect to disciplinary action. Those responsible in DRE for the administration of the Illinois Controlled Substances Act conduct routine investigations to assist physicians in maintaining proper records, for their protection as well as in public interest.

In all areas of inspection and investigation, it is necessary to receive complaints from valid sources. We have been saying to the membership of the professional associations that it is to their advantage to place complaints through their organizations if individuals feel understandable reticence in personally reporting to DRE. We find that professionals often are in better position to identify violations which are occurring within the practices. We feel it is important that medical registrants should individually take more active part in this awareness and in reporting violations to the Medical Practice Act and/or the Illinois Controlled Substances Act.

There is now proposed legislation for expediting the legal process by establishing a Medical Disciplinary Board in DRE.

Department Systems Council

There have been other internal measures taken, one major step being formation of a Department Systems Council in July, 1973. It is a representative body of staff and management designed to evaluate and recommend procedures leading to optimum organization, utilizing concepts of management by objectives. Its initial orientation activities are developing now into significant efforts touching all sections, examining committees, and each aspect of our work.

Medicine

Concerns for medical practice also occupied our attention in the last year. Often it is impossible to separate the regulation of physicians from the effect such regulation has upon medical practice. Early in the year it was determined necessary to define acupuncture as a surgical process to be limited to physicians licensed to practice medicine in all branches; chiropractors were notified that the Examining Committee found acupuncture outside chiropractic practice. By late-year, DRE concurred that acupuncture be limited to medical schools in good standing, in DRE judgment, when carried on primarily for scientific investigation; we must yet resolve other interpretations, although we have determined that DRE cannot legally regulate the teaching of it.

The legalization of abortion in Illinois, presenting

another controversy of frankly immeasurable ramifications, demanded much time and consultation with the Departments of Public Health, Mental Health, Public Aid, and with legislators and health care professionals, seeking to provide realistic, feasible controls compatible to the jurisdiction of each authority. DRE supported the legislation prepared by Public Health officials, considering the ultimate passage as wise.

The question of the Limited Physician License for State Hospitals was resolved, following years of confusion in this area. Both the Department of Mental Health and DRE supported the decision that expiration dates for all permits is July 1 with renewal subject to exam akin to Day II of the FLEX, and that new candidates must have ECFMG Certification. Though a Court Order was handed down exempting permit holders of 10 years, we are working to establish a "permanent permit" category so that all future registrants will have been found qualified. The first limited physician examinations, scheduled for four locations February 6, were designed to bring the exam to the candidates, as opposed to one location requiring possible travel of some distance.

The agency is discontinuing the administration of the FLEX in parts to the Osteopathic student, initially offered because Osteopathic students cannot participate in the National Board Examinations, in that other students were requesting the same privilege in greater numbers than could be accommodated. However, DRE is currently considering recognition of the American Osteopathic Association Examinations to meet this licensure need.

Conclusion

These matters are brief in overview of the many considerations made in 1973; we must realize there shall be greater challenges during 1974. We are dedicated, therefore, to cooperative communication leading to service which fulfills the obligation of the agency to its registrants and to the citizens of Illinois, and salute the membership of the Illinois State Medical Society for its ever-continuing efforts to share in policy-making for the future of the healing arts.

Dean Barringer, Ph.D., *Director*

President's Night

Honoring

Willard C. Scrivner, M.D.

President

Illinois State Medical Society

Thursday, April 4, 1974

Grand Ballroom

Conrad Hilton Hotel

6 p.m. Reception

7 p.m. Dinner

Entertainment by the "First Nighters"

Environmental and Community Health

COUNCIL ON ENVIRONMENTAL AND COMMUNITY HEALTH

The Council on Environmental and Community Health has been active in many areas during the past year. The following report details some of those activities.

Getting Report

Following the direction of the 1973 House of Delegates, the council advised the Illinois Department of Public Health that the Illinois State Medical Society was most interested in the implementation of this report. In reply, the Department answered that the Getting Report was of very low priority and no action was anticipated on its recommendations.

Legislation

The Council and its committees studied legislation covering a wide variety of subjects. Among these was a bill to license hearing aid dealers and fitters, and a bill to define acceptable limits of noise pollution. These bills were rewritten to conform to ISMS standards. A package of bills to control the performance of abortions and to establish standards for all ambulatory care centers was prepared by the Maternal Welfare Committee and has been signed into law. Other legislation studied concerned chiropractors performing school physical examinations, a revision of the school code to eliminate the necessity of T.B. tests for school workers, and a bill which would have allowed nurses to treat the common cold. These bills were successfully opposed.

Maternal Welfare Committee

During the last year the work of the Maternal Welfare Committee has been considerably broadened. In the past its activities were devoted to the analysis of maternal death while the tendency recently has been to concern the committee with matters pertaining to maternal health.

On January 28, 1973, the Committee met with representatives of the Illinois Academy of Family Practice, the American College of Ob/Gyn, the Catholic Hospital Association, the Chicago Ob/Gyn Society, the Illinois Ob/Gyn Society, and the Illinois Hospital Association to develop guidelines for the protection of Illinois women who might elect to terminate pregnancies. As a result of this discussion, a set of guidelines was developed which formed the basis for Senate Bills #1049, #1050, and #1051, which constitute the body of law under which abortions are now being performed in Illinois.

In April, 1973, in addition to discussion of maternal death cases, the Committee studied HB-477, changing the marriage certificate; HB-745 establishing perinatal centers for the prevention of disabling defects; HB-1022 and 1023, providing a bonus for sterilization; and three bills having to do with abortion. The Committee prepared a revised premarital health examination form, and the bills for sterilization were opposed on the basis that they provided no counseling.

In September, 1973, the Committee was asked to comment on the use of diethylstilbesterol as a so called "morning after" pill. An article on the treatment of rape and the use of stilbesterol was prepared. Proper premarital testing and genetic counselling was discussed. Also discussed was the reliability and feasibility of gonorrheal cultures. The Committee accepted the advice of the Department of Public Health that current yields were too low to make this a universally acceptable test. The Committee suggested that the Illinois State Medical Society support research to improve diagnostic procedures for the detection of venereal disease, and that tests of proven validity in the diagnosis of venereal disease should be performed prior to the issuance of marriage licenses.

In December, 1973, the Committee reviewed the cytology screening law (PA 78-92) and recommended that ISMS agree in principle with the intent of the law. We believe that vigorous efforts to repeal this law might reflect against the image of the medical society. The Committee urged that no legislation be promoted or supported which put the hospital in the position of practicing medicine or which diminished the prerogative of the physician.

The administraton of oxytocics to patients in labor was discussed and a request made for a conference between the director of the Illinois Department of Public Health and ISMS representatives. The newly published regulations entitled "Guidelines for the Definition of Perinatal Medicine Services in Illinois" were discussed at great length. The Committee recommended a petition for delay of implementation, and a conference with the Department of Public Health on clarification and stratification of care.

Efforts are being made to improve the educational data derived from maternal death case reviews. A final report on the 1972 death studies shows that 52 cases were analyzed: 26 were found to be directly obstetric, 12 indirectly obstetric, and 14 unrelated to obstetrics. Of those directly obstetric, 9 were thought to be due to hemorrage, 4 to toxemia, all either ante-or post-partum eclampsia. Only three were due to infection, and none of these were apparently due to the consequences of abortion. Embolism accounted for five deaths, infectious hepatitis accounted for three deaths of which two were due to serum hepatitis. Three deaths were due to anesthesia and two to other causes.

Insofar as the indirect obstetric deaths were concerned, three were due to cardiac disease, five to vascular disease, one each to reproductive tract and hepatic disease, and two to pulmonary disease. Those cases considered to be non-related revealed two instances of communicable disease, one case of blood dyscrasia, one of malignancy, one of suicide, two accidents, and seven others.

Ten physicians expressed sufficient interest in an investigation of the causes of death to request the opinion of the Maternal Welfare Committee. In half of these cases the cause of death was considered to be directly obstetrical, and one was not in any way related to the

pregnancy.

Your Committee considers it unfortunate that in less than 20% of those instances where death was due to a direct consequence of the pregnancy was there sufficient interest on the part of the attending physician to inquire whether preventable factors had been present.

In the area of preventable factors, there were 25 instances in which it was felt that some modification of medical management might have favorably influenced the patient course, and in ten instances the patient was felt to be totally or partially responsible for her complications. In only one case was it felt the hospital contributed significantly to the patient's problem.

Your chairman would be grossly negligent if he failed to mention the excellent assistance from our consultants, Dr. Louis, Dr. Webster, and Dr. Sampson, along with his gratitude to the members whose attendance and participation in discussion sessions has contributed so much to the educational value of the Committee meetings.

Nutrition

A successful conference on nutrition was sponsored by the Council in October. This conference was held in Rock Island and was attended by a large number of dietitians and other persons in the food industry.

In addition, the Council, in conjunction with the Chicago Nutrition Association and the Chicago Section of the Institute of Food Technologists, will sponsor a symposium on nutrition and food technology during the Illinois State Medical Society Annual Meeting in April.

Ear Nose and Throat Health

The Committee on Ear Nose and Throat Health has been active particularly in the field of legislation. At the request of the Council on Governmental Affairs the Committee reviewed legislation which proposed licensing hearing aid dealers and fitters. In conjunction with the Hearing Aid Dealers Association the Committee prepared ammendments to the bill which will be introduced in the spring session of the legislature. In addition, the Committee prepared ammendments to a proposed noise pollution bill which also will be introduced.

Sports Medicine

The Committee on Sports Medicine has actively aided the University of Illinois Physical Education Department in arranging a program on sports injuries which will be offered to Illinois high school coaches and trainers in the spring. The Committee also is investigating the possibility of publishing a newsletter on sports medicine which will be distributed to all Illinois high school coaches and trainers.

Council

Edward A. Piszczek, *Chairman*

Julius Kowalski, *Vice-Chairman* — Daniel Pachman
John Ballenger — Arthur E. Sulek
Thomas H. Davison — Richard Treanor
Eugene F. Diamond — Richard Hector, *SAMA*
Robert R. Hartman — Marc Rose *I/R*
John Hipskind — Mrs. Joseph Shanks, *Auxiliary*

Consultants

Warren W. Young

Eugene T. Hoban — Roger F. Sondag

Committee on Maternal Welfare

Robert R. Hartman, *Chairman*

Districts	Members and Alternates (alternates in italics)	
1.	William R. Larsen	
	Gordon T. Burns	
2.	William J. Farley	
	Donald M. Gallagher	
3.	Melvin Goodman	
	Charles F. Kramer	
4.	V. B. Adams	
	Ralph Gibson	
5.	William W. Curtis	
	Robert Maletich	
6.	Robert R. Hartman	
	Richard Yoder	
7.	Paul A. Raber	
	Hubert Magill	
8.	John G. Mason Jr.	
	J. Roger Powell	
9.	William B. Skaggs	
	Donald R. Risley	
10.	Arthur A. Smith	
	William J. Malony	
11.	John J. McLaughlin	
	Charles P. Westfall	

Consultants

John Louis — Willard C. Scrivner

Augusta Webster

Committee on Ear, Nose and Throat Health

John Ballenger, *Chairman*

Andreas Kodros — R. Marcus
William Weiss — Guy Pfeiffer

Committee on Sports Medicine

Julius Kowalski, *Chairman*

Eugene Diamond — James P. Campbell

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

The Illinois State Board of Health was organized July 12, 1877, with a working staff of three people and a budget of $5,000 plus $1,000 for contingencies.

Today, nearly a century later, the department employs approximately 1,100 professional, administrative, technical and clerical workers who are engaged in a broad range of health services for the state's 11 million residents. Each year the IDPH administers state and federal funds in excess of 35 million dollars.

One reason for this growth is an increasing awareness of the value of public health and the increasing demands for its benefits. The department assumes additional responsibilities as new health needs are recognized—needs that arise from a burgeoning population with complex health problems.

Office of Consumer Health Protection

Consumer Health Protection is responsible for administering laws related to protecting and safeguarding health. To carry out these mandated, regulatory responsibilities, the unit conducts programs designed to protect the health and lives of Illinois citizens by controlling environmental hazards. These programs are implemented by the units' divisions of Food and Drugs, General Sanitation, Milk Control, Radiological Health and Swimming Pools and Recreation. Inspection and consultation for

program effectiveness are conducted through the eight regional offices, each of which has technical staff members acting as Consumer Health Protection representatives.

Office of Health Facilities and Quality Care

The new office of Health Facilities and Quality Care incorporates the Division of Health Facilities, the Illinois Department of Public Health Hospital and Clinics, the Blood Bank, Blood Labeling and Hemophilia programs of Public Health and Public Aid, and a new responsibility for quality care evaluation.

The programs of the Division of Health Faciilties are based almost entirely on Illinois Statutes, Department responsibilities under Medicare and Medicaid, administration of the Hill-Burton Grant-In-Aid Program, and Health Facility aspects of Comprehensive Health Planning.

Office of Health Finance

The Office of Health Finance is charged with ascertaining that all of the monies paid to health-care providers by the state of Illinois have been paid to the appropriate parties in a timely manner. The office also is charged with developing new reimbursement formulas for hospitals and nursing homes, and also serves as the designated state agency for the Cost of Living Council's Economic Stabilization Program.

Office of Health Services

The Office of Health Services is charged with the responsibility of administering the health care and disease control programs of the Department of Public Health. Programs within its jurisdiction include both those designed to prevent illness and disability and those for assuring quality health care. To accomplish these functions, the Office of Health Services is divided into five divisions: Dental Health, Disease Control, Emergency Medical Services and Highway Safety, Family Health and Local Health Services.

Office of Management Services

The Office of Management Services includes the numerous activities which makes the Department and its programs capable of effective functioning. These services include public health laboratory services; the general public's education and information services; fiscal services which are accountable for maintaining records and processing requests for expenditures and putting together the department budget; data processing services; management general support services and management audit which provide for increasing the overall efficiency and effectiveness of the department.

Advisory Boards to the Illinois Department of Public Health

- Board of Public Health Advisors
- Advisory Board for Clinical Laboratories and Blood Banks
- Advisory Hospital Council
- Hospital Licensing Board
- Immunization Advisory Committee
- Migrant Labor Advisory Committee
- Advisory Board of Necropsy Service to Coroners
- Long-Term Care Facilities Advisory Council
- Radiation Protection Advisory Council
- Renal Advisory Board
- Ohio River Valley Water Sanitation Commission
- Tuberculosis Advisory Committee
- Laser Advisory Committee
- Advisory Committee for the Child Hearing Test
- Hazardous Substance Advisory Council
- Plumbing Code Advisory Council
- Recreational Area Advisory Council
- Committee for Revision of Rules and Regulations for the Control of Communicable Disease
- Advisory Committee for Heritable Metabolic Diseases
- Advisory Committee on Prevention of Accidental Poisoning in Children
- Advisory Committee on Pediatric Lead Poisoning
- Advisory Committee to the Program for Care of Premature and High-Risk Infants
- Youth Camp Advisory Council
- Advisory Committee for Critically Injured Patients
- Grade A Milk Advisory Board
- Governor's Sickle Cell Commission

The Illinois Department of Public Health is a multifaceted organization designed to serve the public health needs of all the people in the state.

We welcome your requests for more detailed information about the IDPH or suggestions for any of its programs.

Joyce C. Lashof, M.D.,
Director

ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES

The Illinois Department of Children and Family Services offers family counseling, protective services for abused and neglected children, foster care, adoption services, day care, residential care for children, help to unmarried parents, homemaker services, and licensing of child care facilities. In addition, it operates three schools for handicapped children, institutional and community-based rehabilitation services for the blind, and the Illinois Veterans Home.

Amendments to the Abused Child Act by the 78th General Assembly now require registered nurses, licensed practical nurses, teachers and other professional school personnel, law enforcement officials, day care center and nursery school administrators, and social workers to report suspected cases of child abuse to DCFS. The law previously required only doctors, dentists, and hospital administrative personnel to report such cases. A recently instituted child abuse hotline in Chicago (341-8592) is designed to make reporting of suspected child abuse cases easier. In addition, supplemental funds for experimentation in child abuse intervention have been made available to ten of the Department's 18 administrative areas—those which show a high incidence of child abuse and have mobilized community support to attack the problem.

The time lag between a medical practitioner's submittal of a bill for services provided a department foster child and receipt of payment for the bill is expected to be narrowed by a new expediting unit in the department's office of field and business management. All bills for medical services to foster children which do not meet requirements of the state Department of Public Aid's payment system will now be sent to the DCFS expediting unit instead of

being returned to the originating physician. Consulting its data files, staff of the new unit will make whatever corrections are possible and return the bill to DPA for reprocessing. If it is necessary to return the bill to the physician, it will be accompanied by a clear explanation of what corrections should be made. DCFS field offices also will have workers serving as liaison to area practitioners to explain mistakes and corrections and review billing procedures. It is expected these measures will reduce the number of returned bills by 80%.

New Medical Care Procedures For State Wards

Richard S. Laymon, guardianship administrator for the Illinois Department of Children and Family Services, reports that new medical/surgical care procedures have been adopted to upgrade the care and protection of the more than 26,000 children presently being served by the department. Now, before Laymon, who serves as legal guardian of department wards, or one of his 13 assistants in eight field offices across the state, will consent to any elective or previously scheduled surgical procedure, consultation and review is sought from medical staff members of the University of Illinois Hospital's Pediatric Clinic. Emergency medical/surgical consent procedures in cases where the ward's life or health may depend on immediate attention and action by the local hospital emergency room staff are based solely on the advice and recommendation of the physician in attendance.

Further, the guardianship administrator has initiated an ongoing review, with the assistance of medical consultants, of all medical care programs—including the administration of prescription drugs of all kinds—conducted by child care and treatment facilities in which the department places its wards.

Additional information may be secured from Mr. Laymon at 524 South Second Street, Springfield 62706, telephone (217) 525-6533.

Jimi Ann Lawrence

"The Drug Scene—Doctor"

Friday, April 5, 1974

2:00 – 5:00 pm

Conrad Hilton Hotel Chicago

This three-hour program consists of five exposure sessions. They are as follows:

1. Mr. David Selag, Executive Director of the Dangerous Drugs Advisory Commission, explaining his commission's function.

2. Dr. Edward Senay, Director of the Illinois Drug Abuse Program, identifying "resources for rehabilitation programs" in Illinois.

3. Dr. John Chappel, Clinical Director of IDAP, to discuss "addition personalities."

4. Mr. Fred Schick, Coordinator of Youth Services, IDAP, presenting symptomalology and "polydrug clinics."

5. Emergency Treatment of ODs and Toxic Reactions including a 20 minute film of Dr. Gay in California concluding with an overview question and answer session.

Finances and Budgets

REPORT OF THE SECRETARY-TREASURER

This year—1974—the Illinois State Medical Society and the Chicago Medical Society are again jointly sponsoring the **Midwest Clinical Conference,** a meeting with three avowed purposes—a most comprehensive medical conference offering wide and extensive postgraduate educational opportunities for all physicians of the midwest area; the provision of a socio-economic and health-care-delivery discussion forum specially geared to the needs and problems of Illinois physicians; and the development of cooperative and harmonious unity for mutual benefit of the two societies as well as the physicians of the State. Such were the basic goals of this combined symposium at its inception in 1972. How well they have been achieved and how successful the 1974 and future such meetings will be is a matter of viewpoint—and who is doing the viewing.

Most assuredly many advantages and betterments have accrued from the combination, but if these are to be rated on the basis of attendance, the score would be laudable but not spectacular. Days have been saved for many physicians by combining these two important meetings, yet the attendance has not skyrocketed. The increased number and variety of high caliber scientific sessions and postgraduate courses have been outstanding, yet the attendance. . . . The unique opportunity for those attending primarily for educational purposes to also participate in forums on today's socio-economic, organizational and political problems besetting the profession is a big bonus, yet the attendance. . . . Each year more specialty societies have joined the conference, held section meetings and presented excellent discussions, yet the attendance. . . . Scientific exhibits, because of the great number requesting space, have been carefully screened, yet the attendance. . . . More floor space, along with better arrangement, has been allocated for the commercial exhibitors and pharmaceutical representatives, yet the attendance. . . .

It is obvious that good attendance is essential to the success of a multifaceted meeting such as the Midwest Clinical Conference. From the exhibitors' viewpoint, crowds are the keystone.

As a matter of fact, it is so vital that the 1974 attendance may determine whether the meeting can or should be continued in its present form. This could be a crucial year—the year of decision. In this, the basic solution lies with the interest of the members—their desire to attend and their participation in the various segments of the meeting, especially a visit to the exhibit hall. Without the support of those companies which expect physicians to visit their booths, the meeting would suffer severe financial dehydration.

The '74 meeting should be outstanding. It has all the elements to make it so. The problems and difficulties of the past two years have been eradicated. New features have been added. The discussions, both educational and economic, have been updated to an April, 1974, status. A review of the preliminary program shows a diversity of subjects and topics to appeal and be important to every Illinois physician. Here is an opportunity to not only hear and learn but also to be heard and express opinions. Without this kind of exchange, especially the input from the members, ISMS cannot function effectively, with efficiency, and properly reflect the desires of the majority.

The overall arrangements of the '74 meeting have been in the capable hands of the "Joint Management Committee" of which Paul W. Sunderland, M.D., is general chairman. His years of State Society activities, serving as a delegate and six years as Vice-Speaker/Speaker of the House of Delegates, well qualifies him to know what a successful meeting should be. Programming for the meeting, both scientific and clinical, has had the utmost in screening and scrutiny by Robert T. Fox, M.D., and his program committee to assure a diverse yet balanced agenda. Other members of the Joint Committee, Drs. Vincent C. Freda, Harold A. Sofield, Fred A. Tworoger and myself have filled key positions in planning and arrangements. Two top staff members, CMS's stalwart Robert Lindley and ISMS's faithful Perry Smithers, have been given the many responsibilities of implementation.

An appeal is made to attend the '74 meeting. As a practicing physician and Society member, this conference is important to you and you are needed for it. The apathy of the past several years is not readily explainable, considering the many monumental problems facing the medical profession and the need to do something about them. In today's controversies the physician should stand as father of the immediate medical family and patriarch over all health care providers. Even less explainable is the seeming indifference of the past two years, for one of the major thrusts of programming for this conference has been in the avenues of greatest interest and concern to the physician—continuing education and governmental controls. Despite the acknowledged desirability and need for periodic refresher courses and new fields of study, there is no question but that lurking not too far down the road are undefined requirements for relicensure to continue practice. Possibly more vital is the imminent confrontation of physicians and the Federal government. With controls of existing programs constantly expanding, new plans being born, and others possibly being conceived (for the bureaucratic field is fertile), the limitations and controls eventually imposed could seriously restrict the freedom with which medicine's miracles can be delivered. Again it is reiterated, the Officers, the Board, the Committees and the Staff cannot function effectively and implement policies which are the will of the majority unless the members participate actively and make known their opinions and desires.

Membership

Membership statistics for the past six years are listed in the accompanying table. As reflected by this data, total membership has continued to increase in each year. It should be very favorably noted that regular membership in 1973 has significantly increased after many years of near dormancy. This has been due primarily to increased emphasis and activity by membership committees and the realization that membership is equally beneficial to the individual as well as the Society. A major percentage of the 1973 membership increase is the result of the efforts of the Chicago Medical Society. Eagerly awaited is the total membership figure for 1974—which will reflect the effectiveness of the AMA membership drive.

For the first time in this report we are providing, by county, a full listing of paid ISMS membership for 1973.

ISMS Computerized Membership Service

ISMS has, for several years, offered to, and performed without charge, a direct dues billing and collection service for County Medical Societies desiring such assistance. This has been done in several variations.

Billing of Annual Dues: ISMS prepares annual dues

	1973	1972	1971	1970	1969	1968
Membership as of January 1	10,914	10,798	10,692	10,650	10,627	10,568
New Members	846	509	426	354	370	425
Reinstatements	32	43	27	28	46	40
Total added	878	552	453	382	416	465
Dropped during the year:						
Died	152	173	146	145	190	205
Moved from State	97	57	49	73	66	50
Resigned	28	43	37	12	13	6
Nonpayment	123	157	121	110	124	145
Total dropped	400	430	353	340	393	406
Membership as of December 31	11,392	10,914	10,792	10,692	10,650	10,627
Regular	9,690	9,323	9,399	9,405	9,389	9,375
Residents	431	406	276	207	223	196
Service	40	52	63	126	101	105
Emeritus	566	568	514	463	472	507
Retired	574	519	484	456	434	403
Hardship	42	46	56	35	31	41
Intern	49					
Total	11,392	10,914	10,792	10,692	10,650	10,627

billing for 90 of the 91 local medical societies. ISMS supplies the dues bill form for all County Societies.

Collection of Annual Dues: ISMS performs the direct collection of dues for 75 Counties. This means that ISMS mails the annual dues billing directly to the physician. We provide return payment envelopes, which direct remittances to a bank lock box. Each County's dues bills are prepared with the County name, and County Secretary-Treasurer imprinted on them, so physicians issue checks payable to their County Society. Periodic lump sum checks are issued directly to County Societies, ISMS and AMA from the Lock Box. This system facilitates a speedy transfer of funds with minimum manual office effort.

Within this system, eight local societies of the Woman's Auxiliary have the advantage of ISMS billing and collecting their annual dues.

County Societies not as yet taking advantage of this computerized program, either partially or totally, may do so by making their request in writing to the Secretary-Treasurer.

Leadership Conference

As it has for several years, ISMS conducted a Leadership Conference to familiarize members, especially those in county medical society leadership positions, with current activities and concerns.

The 1973 Conference, held at the Drake Hotel on October 21, heard vivid discussions on two timely subjects, Malpractice and State Government and Medicine. The meeting was attended by over 200 physicians.

Starting the morning session with a review of Malpractice from a National standpoint, was AMA's Immediate Past President C. A. Hoffman, M.D., a member of the HEW Secretary's Commission on Medical Malpractice. This was followed with a re-enacement of a portion of a malpractice trial presented by members of the Medical-Legal-Dental Relations Committee of the Illinois State Bar Association.

The afternoon topic, Medicine and State Government, was preceded by a luncheon hosted by Smith, Kline and French. The luncheon speakers discussed current and projected federal legislation affecting the drug industry, with a warning of handicaps and restrictions in proposed legislation. Also at the luncheon, Astronaut Capt. J. P. Kerwin, a physician who is a native of Oak Park and a Northwestern University Medical School graduate, was given honorary membership in ISMS.

Illinois Lieutenant Governor Neil Hartigan opened the afternoon session with remarks concerning his responsibilities in the health area, especially for the senior citizens. His remarks received wide acclaim and excellent response in the way of questions. This was followed by an hour-long question and answer session with the members of the Walker Health Cabinet:

Joel Edelman, Director, Illinois Department of Public Aid

Joyce Lashof, M.D., Director, Illinois Department of Public Health

Mark Lepper, M.D., Director, Comprehensive State Health Planning Agency

LeRoy P. Levitt, M.D., Director, Illinois Department of Mental Health

A panel discussion on the Key Man Program, featuring veteran Key Men Philip Thomsen, M.D., Jack Gibbs, M.D., George Mitchell, M.D., and Mrs. Alan Taylor concluded the day's program.

Leadership Conferences are one of the Society's most effective methods of improving communications within the membership and discussing issues on an open basis. While no one date and no two or three subjects can satisfy each and every member, programs are predicated, insofar as possible, on "hot" or controversial issues. Since this meeting is intended to be the members' forum and vox pop, suggestions and ideas should be expressed as to what should be presented.

Illinois State Fair Exhibit

More than 10,000 persons had their blood pressure taken at the Illinois State Fair exhibit co-sponsored by ISMS, Ciba Pharmaceutical Co., Sangamon County Medical Society and the Renal Unit of Springfield's Memorial Medical Center.

Volunteer health workers recorded above-normal blood pressure in 21.9 per cent of the 10,188 registered visitors. Each person whose blood pressure registered above the norm was given a record of the reading and advised to see his physician. Such testing gave physicians a unique opportunity to learn patients' blood pressure under everyday situations quite different from the physician's office or the hospital setting. In addition, a statistical record of each above-normal blood pressure reading was sent to the Ciba Pharmaceutical Co. for inclusion in a national survey now being conducted.

The exhibit attracted more attention from Fairgoers than any other ISMS project in recent years. The Society has sponsored health-education exhibits at the State Fair for over 20 years and is the only project wherein it has a direct contact on a person-to-person basis. Specially prepared for 1973 State Fair distribution was a new eight-page brochure "What Has I.S.M.S. Done For You Lately?" —"How the Illinois State Medical Society Safeguards your Health." Written in language readily understood by the lay public, it covered such subjects as "Cutting Costs of Health Care," "Maintaining Quality of Health Care," "More Doctors to Provide More Care," "Partners in Safeguarding Health," and ISMS Health Education."

The ISMS exhibit, in an established location for years at the State Fair, has always featured exhibits, literature and information publicizing the interest of Illinois physicians in the health of the State's men, women and children. Through honesty of advice and accuracy of health information, it has earned the respect of many Fairgoers who return yearly for new or additional literature.

1973 Financial Reports

The preliminary (unaudited) December 31, 1973, year end Financial Report of ISMS, with 1973 budgets and 1974 budgets will be mailed to each Delegate by February 19, 1974. This will enable each Delegate to review the Society's financial position, results of operations, and future planning prior to Reference Committee hearings. At the time of this writing, scheduling with our auditors, Peat, Marwick, Mitchell & Company, will allow the final 1973 audited report to be passed out on the floor just prior or during the assembling of the House.

Finances

As anticipated in this annual report last year, the 1973 financial results (based on unaudited and preliminary data) improved considerably when compared to 1972. ISMS net operating income totaled $1,076,471, while expenditures were only $1,055,613 resulting in a surplus of $20,858 for the year. The Board of Trustees had approval a final balanced budget (both income and expense) of $1,032,625. Income exceeded this amount by $43,846, while excess expense totaled $22,988.

Revenue to cover the administration of the Liability Insurance program, unbudgeted as it began in mid-year, accounted for $17,100 of the excess income. The remaining $26,676 is attributed to dues from increased membership, investment income and staff service income. Increases in these items were more than sufficient to offset *Journal* revenue which fell $11,837 below projections.

Excess expense of $22,988 included $16,066 of unbudgeted cost for administration of the liability program. Excluding this expenditure we exceeded our projected budget by $6,922 or only 6/10 of 1% during a year when the cost of doing business increased over eight percent.

Along with our normal allocations for AMA/ERF, Benevolence and *IMJ* subscriptions in 1973, we provided for the Standard Allocations as determined by this House; Permanent Reserve-$51,924, Benevolence-$9,441, Contingency Reserve-$9,441 and $56,170 to wipe out the then expected accumulated deficit at December 31, 1972, an amount which proved to be under estimated by $11,037.

Taking into account our deficit operating fund balance of $11,037 at the end of 1972, and our 1973 surplus of $20,858, we leave 1973 with a net accumulative operating fund surplus of $9,821, a good start on our current "Five Years Dues Maintenance Plan," our guide for financial stability through 1977.

Under this plan, a formulated arrangement of deposits and withdrawals for specific years, comparatively large amounts of the dues increase are apportioned to the standard allocations during the first two years (to take advantage of investment income) and then, in the case of the Contingency Reserves, graduated withdrawals are

1973 ISMS Payments

	Active Members			Interns & Resident Members		Prior Years	
	Full	½	¼	Full	Half		Total
Adams	70	2					9,301.00
Alexander	3						393.00
Bond	8						1,048.00
Boone	13						1,703.00
Bureau	19						2,489.00
Carroll	7						917.00
Cass	3						393.00
Champaign	180	4				109.00	23,951.00
Chicago (Cook)	5,295	293	96	377	98	1,425.00	721,665.50
Christian	19	2					2,620.00
Clark	5						655.00
Clay	7						917.00
Clinton	11						1,441.00
Coles-Cumberland	36						4,716.00
Crawford	12	1					1,637.50
DeKalb	49						6,419.00
DeWitt	8						1,048.00
Douglas	9	1				2.00	1,246.50
DuPage	370	13	10	14		354.25	50,143.25
Edgar	15	1					2,030.50
Edwards	2						262.00
Effingham	18						2,358.00
Fayette	8						1,048.00
Ford	8						1,048.00
Franklin	20						2,620.00
Fulton	23						3,013.00
Gallatin	1						131.00
Greene	6	1					851.50
Hancock	9						1,179.00
Henderson	1						131.00
Henry	25						3,275.00
Iroquois	17						2,227.00
Jackson	47						6,157.00
Jasper	2						262.00
Jefferson							
Hamilton	31	3		1			4,267.50
Jersey-Calhoun	9	1					1,244.50
JoDaviess	7						917.00
Johnson							
Kane	239	5	2			27.25	31,729.25
Kankakee	82						10,742.00
Kendall	7						917.00
Knox	55	1					7,270.50
Lake	238	6		1			31,581.00
LaSalle	75	8		1			10,359.00
Lawrence	6	1					851.50
Lee	20	1					2,685.50
Livingston	25						3,275.00
Logan	18						2,358.00
Macon	133	2					17,554.00
Macoupin	18	1					2,423.50
Madison	112	8					15,196.00
Marion	35						4,585.00
Mason	6						786.00
Massac	4						524.00
McDonough	22	2		1			3,023.00
McHenry	53	2		2		109.00	7,203.00
McLean	84						11,004.00
Menard	1						131.00
Mercer	4						524.00
Monroe	7						917.00
Montgomery	14						1,834.00
Morgan	38						4,978.00
Moultrie	5						655.00
Ogle	16						2,096.00
Peoria	227	1					29,802.50
Perry	10	1					1,375.50
Piatt	5						655.00
Pike-Calhoun	9						1,179.00
Pulaski	1						131.00
Randolph	14						1,834.00
Richland	17	1					2,292.50
Rock Island	140						18,340.00
St. Clair	183	3		2		218.00	24,407.50
Saline-Pope-Hardin	24	2					3,275.00
Sangamon	215	9		3		54.50	28,839.00
Schuyler	3						393.00
Shelby	6						786.00
Stephenson	47						6,157.00
Tazewell	38						4,978.00
Union	5						655.00
Vermilion	66						8,646.00
Wabash	13						1,703.00
Warren	4	1					589.50
Washington	2						262.00
Wayne	6	1					851.50
White	8						1,048.00
Whiteside	33						4,323.00
Will-Grundy	166					113.00	21,859.00
Williamson	24					218.00	3,362.00
Winnebago	261			1			34,201.00
Woodford	8						1,048.00
TOTAL	9,225	378	108	403	98	2,630.00	1,243,921.00

made until the end of the plan's "term" in 1977. Hopefully, in the absence of too many expensive special projects, no greater escalations in the cost of doing business and no unforeseen catastrophic events, the Society's yearly finances should remain solvent and the budgets in reasonable balance through 1977.

The projections for 1974 also look favorable for the second consecutive year. The Finance Committee has developed a balanced budget with a preliminary estimated total of $1,123,045, which is 4% above last year's income. This budget provides for 6% or $67,432 increase over 1973 expenditures. In addition to the 1974 budget a 1975 proposed budget will be provided to each member of the House, prior to the 1974 meeting.

At this point the usual words of caution and admonition must be repeated. Neither the '74 budget nor the '75 projection contain any "fat" or uncommitted funds. The 6% increase included in the 1974 budget will be more than consumed by the necessary escalations in salaries, materials and services. Consequently, any new major projects or programs envisioned by the House must be accompanied by a fiscal note as to the method of financing—fully weighed as to desirability of implementation as contrasted to the sacrifice of the deletion of one of equal monetary value.

Permanent Reserve & Benevolence Trust Fund Investment Analysts

The Continental Illinois National Bank and Trust Company of Chicago is the Trustee for the ISMS Trust Funds. The Certified Public Accountants, Peat, Marwick, Mitchell & Company, examine the fund each year, and their report is included within the ISMS Audit Report provided to each Officer, Trustee and Delegate at year end. To avoid any possibility of the appearance of conflicting interest within the medical profession, the names of individual equities within the fund are not made available to the membership until the accountants' report is mailed three months after year end.

To provide further accountability and protection of these assets, your Finance Committee has the brokerage firm of A. G. Becker & Company statistically evaluate the performance of our Trust Funds as compared to 50 other funds of similar size and nature.

The Finance Committee meets periodically with our Funds Trust Manager, and representatives of A. G. Becker & Company to analyze investment results.

Cumlative Performance Summary
As Provided By A. G. Becker & Co.
1968 Through 1972

	Total Fund Return	Equity Return	Fixed Income Return
Maximum	14.20%	13.13%	9.55%
Median	6.67	9.35	4.71
Minimum	1.71	5.07	0.16
ISMS Fund	10.31	13.13	4.21
ISMS Rank*	3	1	65

**Indicates percentage of funds which out performed ISMS Fund.*

Accumulative dues contributions to the Permanent Reserve Fund for the period ending December 31, 1972, totaled $527,313. Market value of the Permanent Reserve Fund at that date equaled $859,137.

Investment market value of the Benevolence Fund at December 31, 1972, equaled $258,291.

At the time of this writing, A. G. Becker & Company's performance results were not yet available for the year 1973. The investment climate in 1973 was less than satisfactory as reflected by all leading market indicators. We may anticipate a substantial decline in market values for the year.

Benevolence

Although the number of persons receiving assistance from the Benevolence Fund decreased slightly in 1973, the needs of those remaining on the rolls are becoming more acute because of the rapidly increasing cost of living. There are 25 benevolence recipients, four doctors and 21 widows, receiving monthly payments up to $250. Total average paid out each month last year was $5,004.00.

During the year, several recipients appealed for increased assistance and the report of financial status requested annually from each recipient is likely to cause the committee to consider adjustments in several cases.

The investments of the Benevolence Fund are made and managed (with approval of the Finance Committee) by the Trust Department of the Continental Illinois National Bank and Trust Company. It is to be noted that the Benevolence Funds are "pure;" every dollar allocated by the Society or monies donated to the Fund are used for benevolence. The bylaws specify that all custodial or administrative expenses concerning benevolence be borne by the society.

The society is again grateful to the Womans' Auxiliary for its contributions to the fund. Initially conceived by the Auxiliary as one of their projects, annual contributions have been received, and in 1973, these contributions amounted to approximately 15% of the total assistance payments.

Additional contributions are welcome as the society strives to increase the fund to the point where the return on investments will provide the amount needed for annual benefits.

Since the avowed policy of the Fund precludes any portion of its accumulated reserves being used for monthly assistance, if inflation continues to any appreciable degree or the number of needy recipients grows, it may become necessary to recommend to the membership that their annual contribution be increased. The 100% benevolent use of contributions (a rarity in charity) and the direct professional family usage should make such a recommendation 100% acceptable.

Conclusion

To the Staff of ISMS I again pay tribute for their continued loyalty, demonstrated service and cooperative efforts. True to the tradition of the physician, they know no eight-hour day or five-day week and, as is so often true of many on a health team, they are often silent partners to the success of an important project. Intensely concerned with the betterment of health care and in the quest of seeking new achievements for the Society, their suggestions and ideas have frequently become incentives of the first order. In crisis and out, they have proved their worth and merit our sincere esteem and commendation.

The Society has had an eventful year. New and unusual issues have confronted the Officers and Trustees as well as the membership. Decisions and solutions have not always come easily. That there have been conflicting ideas, differences of opinion and controversies on some matters should in no way be construed as evidence of weakness or open rift. Instead, such discussions should be looked upon as harbingers of strength and progress, for open discussion and honest expression of opinion, if pursued, eventually lead to unity and greater vitality. In this time of challenge and attempted domination of medicine's freedom and rights, an open forum of discussion and expression should be encouraged and continued. However, as honorable men and with humanitarian interests, all dialogue and proposals should be tempered with reasonableness and factuality as well as co-equality for all concerned. We have a job to do—let's work as a team.

Jacob E. Reisch

Governmental Affairs

GOVERNMENTAL AFFAIRS COUNCIL

The 78th Illinois General Assembly convened on January 10, 1973. Major health issues included certificate of need, new HMO regulations and abortion. Of the 3,210 bills considered by the legislature between the months of January through June, 1973, about 500 were related to health care; approximately 300 of those were of significant interest to the medical community.

Fortunately, the Illinois physicians joined in the Springfield legislative battles. Large numbers of physicians provided expert testimony, phoned their respective legislators and wrote personal notes expressing interest in specific topics.

It has become increasingly evident through each succeeding session of the General Assembly that physicians must fight for the profession and the needs of the public or capitulate to bureaucratic domination.

The following analysis is a condensed report of the legislative activities of your Governmental Affairs Council during 1973.

ISMS Legislation

Good Samaritan Concept: On July 28, the Governor signed into law S.B. 450 (P.A. 78-385), which amended the Medical Practice Act by stating that "a physician who in good faith and without prior notice of the illness or injury provides emergency care without fee to a person, shall not, as a result of his acts or omissions be liable for civil damages." The bill also set forth a definition of an emergency situation to circumvent situations where a physician might make an error in treatment, not charge a fee and call it an emergency. The words "and without prior notice of illness or injury" clarify what an emergency situation is. It is hoped that this law will strongly encourage physicians to render good faith medical treatment in all situations.

Mental Illness Insurance Coverage: Legislation (S.B. 881) was introduced during the 78th General Assembly to guarantee minimum in-service coverage for mental, nervous and emotional disorders at the purchaser's option, in all health insurance policies. This bill corrects a discriminatory practice of many insurance companies against the mentally ill. Passage would have enabled Illinois citizens to obtain care within their communities through the private sector, thus reducing the patient load in state facilities and the tax burden on Illinois citizens. While the bill was defeated in the Senate, it is expected that ISMS will again introduce this proposal.

State-Wide Medical Examiner System: ISMS developed H.B. 687 which would have established a state-wide medical examiner system to replace the present coroner system no later than December 6, 1976. Inspired by the workings of the ISMS Ad-hoc Committee on Forensic Medicine, we sought to replace the coroner's office with a workable and competent Medical Examiner System. The Medical Examiner system provided for a five member Medical Examiner Board appointed by the Governor which in turn was empowered to appoint a Chief Medical Examiner to administer the system. The bill also provided for the appointment of District Medical Examiners in geographically compact areas around the state. Unfortunately, the bill was defeated on the floor of the House after a very tough fight. The ISMS is expected to again initiate this legislation.

Legislation ISMS Supported

Human Blood, Organ and Tissue Liability: On June 22, 1973, the Governor signed into law S.B. 110 (P.A. 78-31) which extends the exemption of liability relating to the use of human blood, organs or tissue. In 1971, an Illinois Supreme Court decision declared hospitals liable for serum hepatitis contracted by a patient following a blood transfusion. Further liability of blood transfusions would have also extended to donors, blood banks and physicians if the 77th General Assembly had not taken swift and precautionary measures by passing a bill exempting from liability those persons involved in all transactions relating to blood and blood derivatives. Although passed by the 77th General Assembly, the exemption only extended to July 1, 1973. Senate Bill 110 now law, extends this exemption of liability to July 1, 1976. It is hoped by the medical community that this greatly needed additional time period will allow medical science to develop a reliable test for hepatitis virus in screening blood donors.

New Drugs, Federal Application Required: The medical community supported a bill amending the Illinois Food, Drug and Cosmetic Act which passed both bodies of the General Assembly and was signed into law by the Governor on September 7, 1973 (P.A. 78-599). Senate Bill 556 added a requirement to the Food, Drug and Cosmetic Act stipulating that a federally approved application for the sale or use of any new drug be filed with the Director of Public Health if the drug is manufactured in Illinois. The new law prohibits the use in humans or animals of any new drug limited to investigational use unless an application for an exemption has been filed with the Federal Food and Drug Administration and such exemption has not been terminated, unless such application has been filed with the Director of Public Health if any portion of the investigation is conducted in Illinois and unless the drug is plainly labeled in compliance with federal law.

Eye Examinations: Senate Bill 816 which required an optometrist to refer his patient to a physician licensed to practice medicine in all of its branches if the patient exhibited symptoms of serious ocular ailments was tabled in the Illinois Senate per the request of the Illinois Ophthalmologic Society.

Physician's Personal Presence Not Required: S.B. 1099 attempted to amend the Illinois Nursing Act by stating "Nothing in this Section shall be construed to require the personal presence of a licensed physician or dentist at the place where the described nursing acts are performed." The bill, per the request of its sponsor, was tabled in the Senate.

Mental Health Code: A series of Senate Bills 824, 825, 826, 827, 829 and 830 were supported by the Medical Society. The bills' general direction attempted to amend various sections of the Illinois Mental Health Code as related to psychiatric concurrence for an absolute patient discharge, powers and duties of the Mental Health De-

partment, Director of IDMH to furnish a list of drugs that may be administered in institutions, regular inspections of IDMH facilities by the IDPH, separation of sexes pertaining to sleeping quarters, and providing that IDPH in conjunction with Mental Health shall prescribe standards for facilities for the mentally retarded. The following bills were passed and approved by the Governor: S.B.s 826 (78-541), 827 (78-758), 829 (78-542), and 830 (78-759).

Illinois Abortion Law: In January, 1972, the U.S. Supreme Court ruled that the state cannot interfere in a doctor-patient decision to perform an abortion in the first trimester of pregnancy, and therefore Illinois law was voided.

On July 19, 1973, Governor Walker signed into law the first of three bills establishing abortion criteria in Illinois. Senate Bill 1049 (P.A. 78-225) permits only physicians to perform abortions. During the second trimester, a physician may perform an abortion only in a hospital and on an in-patient basis where life support equipment is available. In the third trimester, two other physicians must agree that abortion is necessary to preserve the life, physical or mental health of the mother. A "conscience clause" protects physicians refusing to perform abortion from civil, criminal, administrative or disciplinary action. The law also prohibits experimentation upon aborted tissue.

Performance of Abortions: Senate Bill 1050 which was signed by the Governor on July 19, 1973, (P.A. 78-226) restricts the performance of abortions to licensed facilities, including ambulatory surgical centers. It also amends the Medical Practice Act to make performance of elective abortion in an unlicensed facility grounds for placing the physician on probation, suspension, or revocation of his license to practice medicine.

Ambulatory Surgical Treatment Centers: This measure was the third abortion related bill signed by the Governor on July 19, 1973, (P.A. 78-227). This act, while not directly related to abortion, would assure that such procedures are carried out only in licensed and regulated facilities. The law defines an ambulatory surgical treatment center as a facility devoted primarily to medical and surgical procedures, including abortions—which normally would require overnight hospital stay. Centers are prohibited from providing beds or other accomodations, but would be required to transfer to a hospital any patient in need of additional care.

Regulation and licensing of such centers would be the responsibility of the Illinois Department of Public Health. To qualify for licensure, ambulatory centers must be under the supervision of one or more physicians. Only licensed physicians and dentists with hospital privileges to perform surgery can practice in the centers, and medical records must be maintained for each patient. ISMS believes that ambulatory centers will free hospital beds needed for the seriously ill, and reduce the need for hospital expansion.

Rubella Test For Marriage Repealed: A bill (H.B. 35) repealing an act requiring that an affidavit be filed indicating the women's immunity to Rubella (German Measles) before the issuance of a marriage license was signed into law by the Governor on September 10, 1973, (P.A. 78-661). Therefore, it is not a statutory mandate for the physician and County Clerks to require a test for immunity to rubella as a requirement for marriage.

School Children and Immunizations: Illinois law provides for the immunization and booster immunizations six months prior to pupil entering public, private and parochial schools at the kindergarten or first grade and upon entrance into the fifth and ninth grades.

House Bills 158 and 159, signed by the Governor on July 13 (P.A. 78-302 & 303) allow for the codification of these immunizations under the Illinois Department of Public Health. Codification of these immunization schedules under the IDPH allows for the orderly change and public safety of Illinois citizenry by insuring that all required immunizations are updated and reviewed by the State Immunization Advisory Board and the Division of Disease Control. In addition, as medical science develops better vaccines these vaccines can be readily controlled through rules and regulations rather than the arduous task of legislatively changing the law. These laws do not advocate repeal of present immunizations, but change only the orderly codification of immunizations to be added or deleted from the list.

Insurance Coverage of Alcoholism: A bill (H.B. 629), amending the Insurance Code and Health Services Act providing that every group accident and health insurance contract and each group accident and health insurance policy issued by an organization and providing coverage for hospital treatment shall provide coverage for treatment of alcoholism was signed into law by the Governor on September 11, 1973, (P.A. 78-767).

Refusal to Perform Abortions: July 19, 1973, marked the day which set standards for abortions in Illinois. The Governor also signed House Bill 650 (P.A. 78-228) which states that "No physician, nurse or other person who refuses to recommend, perform or assist in the performance of an abortion, whether such abortion be a crime or not, shall be liable to any person for damages allegedly arising from such refusal."

Designated Products: House Bill 982 signed into law on August 28, 1973, (P.A. 78-441) provides for the Director of Law Enforcement to develop a list of "designated products" for which the triplicate prescription form of the state will be required. This process will alleviate some of the problems of having so many items in Schedule II of the Illinois Controlled Substances Act which are not substances of abuse.

Ambulance Services: Under House Bill 1210 counties are authorized to levy a tax by referendum for the purposes of subsidizing existing service or providing such service, if necessary. In addition, general revenue funds of the county may be used for such purposes, with or without the levying of the special tax or having a referendum. ISMS believes this to be an important and useful law for those southern Illinois counties, where ambulance services can either be established or up-graded via tax referendum. Governor Walker signed the bill into law on August 28, 1973, (P.A. 78-456).

Fire Safety in Health Care Facilities: House Bill 1319 establishes the Illinois Health Care Facility Fire Safety Act. The bill requires safety measures for new health care facility construction and within two years all other health care facilities were to meet specified standards. While physician offices were excluded from the bill, all other related facilities were included. Final action on the bill was not accomplished and it was sent to an interim study committee for further study and evaluation.

Amended Legislation

Pre-Marital Examinations: Senate Bill 106 seeks to amend an Act in relation to marriages. The proposed bill deletes the word "thorough" before "examination" in reference to the required physicians examination of mar-

riage license applicants and his certification of their freedom from venereal disease. While the medical society supports the basic intent of the original proposal, ISMS added an amendment to the bill which deletes the wording "all venereal disease," as referring to blood serology. A blood test only denotes the freedom or existence of syphilis and not all venereal disease. This bill was referred to the '74 Spring Calendar of the House of Representatives.

Physician/Assistants: S.B. 321, a bill to license physician-assistants, was defeated in the House. ISMS sought to amend S.B. 321 in accordance with the ISMS House of Delegates' action in 1969. The Illinois Nurses Association, the Illinois Optometric Association and the Illinois Pharmacists Association aggressively opposed S.B. 321.

Foreign Medical Graduates: Senate Bill 501 passed the General Assembly during its regular session and was then vetoed by the Governor. Upon return of the legislature during its special session the Governor's veto was overridden and the bill became law. The intent of this legislation is to permit Illinois residents who are graduates of Foreign Medical Schools to come back to Illinois to intern in an Illinois hospital. The situation stems particularly from the students attending medical school in Guadalajara, Mexico. Under the Mexican Government's policy, a foreign medical school student must serve an extra two years in that country practicing medicine in a rural area before the Mexican school grants the academic degree called a Titulo (or M.D). Most American students refuse this two year service obligation in Mexico and return to Illinois in the hope of practicing medicine. Without an M.D. degree the student can not apply for examination and licensure in Illinois. The law permits the foreign medical school student to return to Illinois and apply for admission through an Illinois medical school, upon which the school can test the student as to determine educational equivalency compared to state norms. The tests can then be used for placement at the appropriate grade level in the Illinois school or advance standing through an internship training program. Upon completion of the Illinois requirements the student is granted an M.D. degree from the Illinois school and becomes eligible for examination and licensure in Illinois.

Follow up on House of Delegates Action

The 1973 House of Delegates adopted and referred the following resolution to the Governmental Affairs Council for implementation:

73M-26 directed ISMS to review and study the Illinois Physical Therapy Act in conjunction with the Illinois Department of Registration and Education to clarify the present law and not preclude any nurse or aide in a hospital or doctor's office from using an ice pack, hot pack, ultra-violet or infra-red lamp or simple therapy devices. The Medical Legal Council has met with representatives of the Physical Therapists Association and will take all necessary action.

Eye Health Committee

The Eye Health Committee has actively reviewed several legislative proposals and is working closely with the Illinois Ophthalmological Association. No new legislation is being proposed at this time.

Ad-Hoc Committee on Forensic Medicine

House Bill 687 initiated by the ISMS Ad-Hoc Committee on Forensic Medicine proposed to establish a State-Wide Medical Examiner System in Illinois. Unfortunately, the bill was defeated in the House of Representatives in 1973.

The Ad-Hoc Committee plans to reintroduce the bill in the '74 Spring Session of the General Assembly.

Ad-Hoc Committee on the Legal Definition of Death

The Ad-Hoc Committee has developed a bill defining death. While a legal definition has been proposed by the Committee, additional scientific studies are being sought by the Committee. If a bill is introduced into the legislature, the Ad-Hoc Committee will seek to amend the bill with the ISMS proposal.

Public Affairs Committee

The Public Affairs Committee sponsored several successful programs in 1973.

Under the 1972-73 Chairman, George T. Wilkins, M.D., the Committee's annual Washington Roundup drew 57 people to the nation's capital for a series of meetings with governmental officials. Highlighting the program was the annual ISMS Congressional Reception, which was attended by 18 of the 24 Illinois Congressmen. A new innovation in 1973 was a post-Roundup trip to San Juan, Puerto Rico, which drew 39 members of the group.

United States Senator John Tower, the Senior Republican Senator from Texas, was the featured speaker at the Public Affairs Breakfest on March 29, 1973. This event drew 230 people during the House of Delegates Meeting in Chicago, including freshman Illinois Congressmen Sam Young, George O'Brien, and Edward Madigan.

Under the 1973-74 Chairman, Elliott Partridge, M.D., the Committee undertook a massive up-dating and reorganization of the Key Man Program. This process included personal communications with each of the hundreds of ISMS members who were considered Key Men. After the records were updated, a new, expandable loose leaf Key Man Manual was issued. A continuing series of mailings will keep the manual current. Efforts to cover all Illinois legislators in this program are continuing.

On October 21, 1973, the Committee sponsored the afternoon session of the annual ISMS Leadership Conference at the Drake Hotel in Chicago. Highlights of the program included an address by Lt. Gov. Neil Hartigan, a question and answer session with the members of Governor Walker's Health Cabinet, and a panel discussion on the Key Man Program.

Also during 1973, the Public Affairs Committee laid the groundwork for a number of important programs in 1974. Among them are:

1. As part of the continuing work on the Key Man Program, the Committee plans a series of state legislative candidate interviews prior to both the primary and general elections. These efforts, as well as all other Key Man projects, will be done in co-operation with local county medical societies.

2. The Washington Roundup, February 3-6, 1974, which was held in conjunction with the winter meeting of the Board of Trustees.

3. The post-Roundup winter vacation trip to St. Maarten in the Dutch Antilles, which was highlighted by a leadership seminar put on by the Illinois Council on Continuing Medical Education.

4. The annual Public Affairs Breakfast, scheduled for 8 a.m. Friday, April 5, 1974, during the House of Delegates Meeting.

5. A Springfield Legislative Conference aimed particularly at Key Men and Auxiliary members, scheduled for May 22, 1974.

6. A pilot project, a "Doctor of the Week Program," that will bring physicians to Springfield during the month of June, 1974, to offer medical testimony in the legislative process.

7. A weekend Legislative Seminar scheduled for September 20-22, 1974, which will bring about 15 legislators and 60 physicians together in an informal setting for an indepth discussion of the legislative process.

Council

George T. Wilkins, *Chairman*

James Laidlaw — Elliott Partridge
Noel Bass — Robert Pierce
George Burke — Robert C. Stepto
Julian W. Buser — Isaias Sunga
Alfred J. Faber — James J. McCoy, *Intern*
Edward G. Ference — Christopher Gilman, *SAMA*
Warren Kreft — Tom Powers, *SAMA*
John W. Ovitz — Mrs. Paul Raber, *Auxiliary*

Consultants

Robert Fox — Frank J. Jirka, Jr.
Willard C. Scrivner — Warren Tuttle
George Shropshear — Mrs. Alan Taylor

Eye Health Committee

Warren W. Kreft, *Chairman*

Frederick Crowley — Edward Kwedar
Maurice M. Hoeltgen — Samuel Schall
Paul Hauser — Frank Snell
Robert W. Webb

Ad-Hoc Committee on Forensic Medicine

Grant C. Johnson, *Chairman*

Thomas P. DeGraffenried — Robert W. Wissler
James H. Ryan — Donal D. O'Sullivan
Robert J. Stein

Ad-Hoc Committee on Legal Definition of Death

Jacob E. Reisch, *Chairman*

Tom Baffes — Fred K. Merkel
Benjamin Boshes — William Dye

Public Affairs Committee

Elliott Partridge, *Chairman*
Robert Pierce, *Vice-Chairman*

Charles Downing — James Laidlaw
Joseph Hinkamp — Theodore Grevas
Earl V. Klaren — Jerry Ingalls
W. Robert Malony — Frank J. Kresca
George T. Mitchell — Thomas P. Meirink
Donal D. O'Sullivan — Tassos Nassos
Edward Ragsdale — Bernard Peele
Eugene Siegel — Ralph Ryan
Lorin D. Whittaker — A. E. Steer
George Wilkins — Mrs. Harlan Failor, *Auxiliary*

Physicians and Auxiliary of the Illinois State Medical Society are cordially invited to a complimentary Public Affairs Breakfast

8:00 a.m. Friday, April 5, 1974

Boulevard Room — Conrad Hilton Hotel

Medical-Legal

MEDICAL LEGAL COUNCIL

A wide spectrum of concerns has been addressed by the Medical Legal Council during the past year.

Resolution 73M-36, calling for investigation of possible extra-legal activities in physical therapy, was referred to this Council and the Governmental Affairs Council. This Council met with the President and Executive of the U.S. Physical Therapy Association and researched the regulations promulgated regarding physical therapy. It was agreed that some isolated cases can be identified wherein persons other than registered physical therapists are performing such therapy and where nurses have prescribed physical therapy. However, the problem is not so large and widespread as to cause official complaint by ISMS to the state. Rather, it is suggested that individual members inform the Department of Registration and Education of specific problems. In addition, the Guidelines for Prescribing Physical Therapy developed by ISMS in 1969, will be republished in the *Illinois Medical Journal.*

Medical Disciplinary Board—early in 1973, the Council reviewed legislation proposed to establish a Medical Disciplinary System, separate from procedures presently existing in the Department of Registration and Education. Several meetings were held discussing this, and a sub-committee developed some basic concepts to be followed. This work is being incorporated in the materials being developed by a special select Committee on Physician Competence, which group will be developing additional materials. This Council will continue to furnish whatever is requested to aid in this activity.

"Right to Die" legislation, which would have mandated certain activities, was not supported by the Council. While there was agreement with the right of a patient to decide on a course of treatment and sympathy for the principle involved, this is not something which should be legislated, but rather left to the interpersonal relationship of the patient.

Privileged Communications and various proposals to infringe upon patient privacy were reviewed. These included proposed changes in Federal Rules of Evidence. various expansions upon Medicare and Medicaid regulations, and other third-party activities. A resolution has been developed for introduction to the House of Delegates reaffirming medicine's belief in the confidentiality of patient communication. To infringe upon this by anyone could have a deleterious effect on the therapy regimen of the patient.

The *Anatomical Gift Act* amendments, proposed by the Society for the Prevention of Blindness, were reviewed and approved. These made it possible for any member of a surviving class to grant authority for an anatomical gift, rather than requiring consent of every member of a surviving class. Related to this was the order of the Illinois Supreme Court over-turning the Leno *vs.* St. Joseph Hospital decision. By this it will no longer be required that each member give consent for autopsy, although any member of the first surviving class may indicate opposition to autopsy, which decision is then binding. The Council is suggesting further modification of the Anatomical Gift Act as such relates to "prior actual notice" by the donor to all possible donees indicating opposition to any donation.

Acupuncture has been discussed and specific ideas forwarded to other ISMS Councils for incorporation into possible legislation and regulation.

Staff developed a booklet of citations of statutes which affect the practice of medicine as a resource item to answer questions of the membership. A program for the Annual Meeting is being conducted for ISMS by the Chicago Academy of Law and Medicine, entitled "The Physician and His Community." The Academy includes physicians who also are attorneys.

Quackery is still with us and a rising incidence of reports on quacks and nostrums caused the Council to recommend reestablishment of a Committee on Quackery. This new committee was authorized by the Board in October and will shortly have some activities underway.

A bill to license *electrologists* has been discussed and, while in abeyance, a member of this Council is to work with the Electrologists Association to develop certification rather than licensure.

Human Experimentation is the subject of another piece of legislation reviewed by this Council. When another Council originally opposed the Bill, an agreed version was developed so as not to eliminate experimental procedures. However, this Council, in reviewing the amended version, objected to the definition of "research" and identified that every patient of every physician could conveivably become a research subject and, by the terms of the bill, an employee of the personal physician to be covered by Workmen's Compensation. This is continuing in development.

A resolution has been introduced regarding *itemized billings* for professional services, which are entirely proper according to the AMA Judicial Council. However, to identify services performed by ancillary personnel, especially personnel functioning extra-legally, could increase liability. The serious attention of the House is directed to that resolution.

Another resolution being introduced regards the *contingency fee* of attorneys in suits for personal injury in medical maloccurances. While the medical profession has generally spoken against this, no official position has been adopted. It is agreed that the contingency fee often has increased the scope and size of an award and has indirectly caused an increase in premiums for professional liability insurance. This also has increased the cost of health care and has perhaps added to the practice of physicians ordering more procedures than really necessary. A definite statement is presented for the House for deliberation so that a policy of ISMS may be developed.

Interprofessional Code

Three versions of an Interprofessional Code exist for the guidance of Illinois physicians and attorneys. There are minor differences between them. However, none address the protection of fee of a physician, the role of the expert witness and his compensation, and the relationship of a physician to opposing counsel and depositions. For nearly a year, a sub-committee of this Council has been working with a counterpart group from the Bar Association Medical-Legal Relations Committee to hammer out a refinement of the Code. Hopefully this will be completed during 1974.

Arbitration

As reported last year, a pilot project for the arbitration of professional liability claims is under development. This has progressed, although not as rapidly as originally hoped. A Joint Administrative Committee has been formed with three ISMS members and three hospital administrators. This group has adopted the implementation guidelines, forms and other necessary materials for the Pilot Project for the Arbitration of Hospital and Professional Malpractice Claims. The American Arbitration Association has been engaged as the administrator of the program. Appropriate review of all materials is being accomplished by legal counsel and the Chicago Bar Association has appointed a small committee to help with the development of appropriate informational items for patients. Some twelve hospitals are targeted for initiation of the program in April, 1974. Insurance carriers have indicated acceptance of the awards, and the program is a proper application of the Illinois Arbitration Act.

The Illinois plan offers a possible alternative to litigation and guarantees to patients a quick, equitable, private resolution to a problem. In addition, a patient must opt into arbitration and has 60 days from date of discharge from hospital to rescind such option. Also, while monetary awards are possible, additional medical treatment or rehabilitation also may be awarded. This is felt to be one of the strongest and best pilot projects in arbitration being attempted in the U.S.

Laboratory Services

Blood banking, tort liability for blood and a volunteer blood donor system occupied this committee for the past year.

An extension of the waiver of liability for blood transfusion was supported. Thus, until 1976, to give opportunity to further research means of identifying bloodborne disease, tort liability will not be applied.

A proposal to lower the age of blood donors from 18 to 15 was made in the General Assembly. The American Red Cross and American Association of Blood Banks now recommend age 17, and the Committee recommends agreement with this premise.

Recent reports indicate that over 98% of all blood presently being utilized in Illinois is from volunteer donors. This is partly a result of the Blood Labelling Act, as well as increased, improved recruitment efforts. National activity is currently underway to set up an American Blood Council to provide a totally volunteer blood supply nationally. Illinois is a pacesetter in this and the Committee will continue to monitor these blood banking activities.

Other activities to which the Committee is addressing itself include proficiency testing for the physician who does laboratory work in his private office, and other legislation regarding laboratory services.

Impartial Medical Testimony

During 1973, the Impartial Medical Testimony Committee was called upon to provide Impartial Medical Examiners for 86 cases, with a total of 175 examinations. A breakdown of the cases according to specialty is as follows:

Allergy/Dermatology	2
Internal Medicine	2
Neurology/Neurosurgery	4
Orthopedic	9
Pediatrics	1
Psychiatry	68
Radiology	1

An extensive effort has been made to update and increase the members of the IMT Panel. The response has been productive and several members have agreed to serve on arbitration cases, if necessary.

The Committee expresses gratitude to the participating panelists who have helped to make this ISMS activity successful for the past 14 years.

Council

David T. Petty, *Chairman*

James Habegger — Clyde Phillips
Clinton Compere — Vincent Sarley
Leonard Klafta — William Schwingel
Donal O'Sullivan — Harold Sofield
Herman Wing — Cheng H. Hsu, I/R
P. John Seward — Sunt Wanasukaput, I/R (alt.)
Gary Skaletsky, SAMA — John Dowdle, SAMA

Consultants

Joseph Bordenave — Allan Goslin
Fredric Lake — Everett Joslyn
Frederick Weiss

Arbitration

Clinton Compere, *Chairman*

David Petty — Vincent Sarley
William Schwinge

Impartial Medical Testimony

Vincent Sarley, *Chairman*

Clyde Phillips — P. John Seward

Laboratory Services

James Habegger, *Chairman*

Coye Mason — Earl Suckow
Richard Novak — Thiru Vaithianathan
Peter Soto — Karl Sohlberg

President's Night

Thursday, April 4, 1974

Mental Health and Addiction

COUNCIL ON MENTAL HEALTH AND ADDICTION

In response to **Resolution 73M-2,** adopted by the 1973 House of Delegates, ISMS has offered cooperation and assistance to the Department of Mental Health. The points raised by the resolution have been forwarded to the Department of Mental Health, and there has been continuing dialogue to try to effect these.

Since the last session of the House, your Council and the Committee on Alcoholism and Drug Dependence have addressed many issues. Some 43 pieces of legislation dealing with mental health, alcoholism or drug misuse and hazardous substances have been reviewed and positions suggested to the Board of Trustees. Space does not allow a listing of all the subjects. Obviously, mental health is something to which the medical community will have to devote increasing attention.

One of the topics which occupied a great deal of time and effort was the proposed Uniform Alcoholism and Intoxication Treatment Act. This was reviewed in depth and a meeting with the sponsors resulted in modifications sought on behalf of medicine. Formal testimony was presented, suggesting that concepts of the Act be instituted in a pilot test area, rather than changing the entire state system without knowing what the result might be. Amendments have been offered by IDMH and IDPH and further study of this is anticipated.

The Medical Practice Act is silent regarding a definition of psychotherapy. However, this is part of the medical model in treating people. Since many paramedical professionals have begun to serve people and offer "psychotherapy," it was incumbent upon the Council to develop a position on this. A definition of Medical Psychotherapy was submitted to and endorsed by the Board of Trustees, with the recommendation that this be included in the Medical Practice Act. A resolution on this has been submitted for deliberation and approval by the House of Delegates. This is especially important in light of state legislation allowing psychologists to bill directly for professional services and the spectre of National Health Insurance on the horizon. Based on many hours of research, discussion and development, the Council urges endorsement of this definition by the House.

Treatment of minors without parental consent was addressed by **Resolution 73M-40.** As this pertained to treatment of minors for mental, emotional or nervous disorders, as well as other considerations, this Council has attempted to develop appropriate legislation. Final agreement on this has not been reached.

Revision of the *Mental Health Code* is being accomplished by a Governor's Commission of 32 members. Eight of these are physicians, two of whom serve on this Council. If any members wish to make comments or suggestions for this Commission, they may be addressed to the chairman of the Board of Trustees for referral.

Mental Health is an aspect of living of great importance to the public. Often individuals cannot obtain care since health insurance may exclude mental health coverage. As a result, the Council has been working to develop legislation to require that health insurance policies include an option to allow coverage of mental illness. A bill was introduced but was unsuccessful. Further efforts are being made. However, one new item in the Insurance Code requires coverage of alcoholism by health insurance. This was supported by ISMS on the recommendation of this Council.

Among the resolutions being presented to the House are several worked on by this Council. In addition to those already cited are:

Alcoholism—a call for refinement in the definition and additional educational efforts. The two resolutions are self-explanatory and have been introduced in an attempt to better meet treatment and rehabilitation needs.

Diagnosis and length of stay—in the treatment of mental illness, diagnosis may not link up directly with prognostic variables. Thus it is difficult, if not impossible, to arbitrarily indicate that in the diagnosis of a particular form of mental illness it will take only a specified time to achieve a patient status whereby further hospitalization is unnecessary. This is not always true in general medicine or surgery either, but the variables in treatment of mental illness are so much greater that there should be recognition of this distinction. A full statement of principles is in a resolution.

Psychiatric home visits—In attempting to return patients to the home and community, often a test home visit is prudent. As this relates to Medicare recipients, it is not possible under current Medicare regulations thus discriminate against the elderly receiving this treatment modality. A resolution has been introduced to try to effect improvement in this situation.

Permit Doctors—A serious problem has plagued Illinois —a dual standard of care as such relates to state mental hospital patients. This has been debated long and loud in several forums. A suggested solution has been developed by the Director of IDMH. This Council has introduced a resolution with some modifications of the suggestion which may help to eliminate this unfortunate quandry. The proposal would permit acculturation of foreign graduates as they achieve full licensure.

Misuse of Medical Prescriptions—Recent state investigations have identified some physicians, as well as others, misusing medical prescriptions and contributing to drug misuse. This should be declared unethical and appropri-

ate disciplinary action should be taken, both by organized medicine and by the state.

Other subjects which have been addressed by this Council during the past year are as follows:

- CPT-III, as such relates to psychiatric services
- Pharmacist review of prescriptions for IDMHDD patients
- Reimbursement of Psychologists by health insurance
- Psychosurgery
- Licensing of marriage counselors
- Developmental Disabilities Act
- Portions of the Domestic Relations Act
- Federal Rules of Evidence and privileged communications
- General aspects of mental health facilities and care
- IDMHDD revised commitment forms
- Elimination of the arbitrary 10/20 day $300 maximums for care of IDPA patients under IDMHDD
- An education symposium on Alcoholism and Drug Dependency
- The Mental Health Code

During the year a position paper was developed and endorsed by the Council. These Idealized Treatment Modalities were distributed by authority of the Board to all members in conjunction with a mailing of several items to the membership. In addition, a research paper on the rights of minors to psychiatric treatment was published in the *Illinois Bar Journal* by a member of this Council.

You are encouraged to attend the educational seminar on "The Drug Scene" during the Annual meeting, developed by the Committee on Alcoholism and Drug Dependence.

Many topics continue in discussion and development. The Council welcomes inquiries and suggestions from the membership of ISMS to help meet the mental health needs of the citizens of Illinois.

Committee on Alcoholism and Drug Dependence

The Committee on Alcoholism and Drug Dependence has met several times and recommended two specific items: redefinition of alcoholism and educational meetings for medical and paramedical personnel regarding drug dependence. Items for action are included in the Council report.

In addition, the committee is working with various state groups to try to iron out difficulties with the triplicate prescription form, in analyzing community alcoholism treatment centers, and is reviewing various proposals relating to misuse of medical prescriptions.

Council

Marshall Falk, *Chairman*

Ronald Shlensky	Donovan Wright
Nathaniel Apter	John Schaible, *SAMA*
Howard Kurland	Bob Gilligan, *SAMA*
S. Dale Loomis	Richard Dudley, Jr., *I/R*
Albert Ray, Jr.	Barry Storter, *I/R* (Alt)
Alex Spadoni	Stearly Alling, *I/R* (Alt)
Thomas W. Stach	W. David Steed

Mrs. Ralph Davis, *Auxiliary Rep.*

Consultants

Joseph Skom — LeRoy Levitt

Harold Nelson

Committee on Alcoholism and Drug Dependence

W. David Steed, *Chairman*

Albert Ray	David Stinson
Charles Anderson	Kermit Mehlinger
George Silvest	Joseph Skom

ILLINOIS DEPARTMENT OF MENTAL HEALTH

The Illinois Department of Mental Health will be renamed the **Illinois Department of Mental Health and Developmental Disabilities** in response to the Department's concern for expanded services to the developmentally disabled and persons with cerebral palsy, epilepsy and related disabilities. Legislative action to actualize the new identity is pending.

Fiscal year 1973 was a year of transition, not only for state government in Illinois, but also for the Department of Mental Health. Midway in the fiscal period, Governor Dan Walker became the state's chief executive and he soon made it clear that he intended to fulfill his campaign promise to do something, at last, about bringing Illinois to the forefront in the treatment and care of the mentally disabled.

A new course was chartered for the Department of Mental Health soon after Governor Dan Walker took office. An aggressive reorganization of the Department was initiated. A Deputy Director for Management and a Deputy Director for Clinical Services and Programs were named. A third Deputy Director—for Developmental Disabilities—was selected later in the year. A significant degree of primary responsibility for day-to-day operational decision making was delegated, through the Deputy Directors, to the state's seven Regional Administrators and the Superintendents of Illinois' 26 state-operated institutions.

Moving with deliberate speed, the new leadership of the Department went to work with focused intensity to put every state-operated and state-supported facility and each program to a simple test. Were the tough requirements and the superior standards of a first class delivery system of care and treatment being met? Programs were changed; many were positions no longer geared to FY-73 objectives. By the end of fiscal year, June 30, 1973, more than 1,000 unneeded positions were abolished. Some of the people involved were assigned other duties or allowed to transfer to other essential jobs within the Department.

It was decided that ancient, worn-out, state-operated facilities were not proper places to house and care for patients. Plans were laid for renovation, where it was clinically and economically feasible. In the case of Peoria State Hospital, built in 1902, Governor Walker ordered it phased out in May, 1973, with the final closing on December 31, 1973.

The closure of Peoria State Hospital, widely regarded as a model closing of an obsolete facility, underlined the commitment to the acceleration of a program of community psychiatry, moving the mentally ill and the developmentally disabled who could benefit from a more home like, more normal milieu, into first class community-based facilities.

State-operated hospitals, however, were still the first priority. More than 90% of the Department's budget is allocated to state hospitals. Despite a dramatic and encouraging decline in inpatient population, the Department

of Mental Health remains sensitive to the needs of the short-term and the long-term chronically mentally ill and the severely, profoundly and multiple handicapped client. A studied program of upgrading and renovating Illinois' 26 institutions is in progress. A higher percentage of institutions than ever before are fully accredited by appropriate national organizations.

Operating with the largest budget in its history, some $337,000,000, the Department was able in FY-73 to increase both the number and the amounts of community grants-in-aid so that those patients, formerly cared for in state hospitals, were not just relocated to smaller warehouse-type facilities, but were placed in an atmosphere conducive to a relatively rapid return to functional ability.

Outpatient treatment and aftercare, each a mandated and accepted responsibility of the Department, moved ahead in FY-73 with increasing momentum. These integral components of the thrust toward programs designed to keep Illinois citizens with mental health problems on their jobs, with their families and friends, living as near a normal life as possible, are a stated objective of the Department.

In FY-73, the first steps were taken towards revamping the system of state-supported community clinics. A continuing effort is going forward to eliminate duplication and avoid waste by strengthening the position of existing facilities—Chicago Board of Health Clinics, hospitals and private treatment centers—which serve mentally disabled outpatients.

This fundamental advance in health care means the allocation of a greater share of the Department's funds for purchased care than ever before. It is in keeping with the management objectives of the Department of Mental Health to build and help maintain a wide community-based delivery system of mental health services for the citizens of Illinois.

Management by Objectives

The general reorganization of the Illinois Department of Mental Health was designed to establish a program of management by clearly-stated quantitative and qualitative objectives.

Objectives for 1974 include the reduction of unnecessary institutional care by 8%; improvement in the quality of inpatient care by increasing the level of direct patient care personnel from 58% to 65%; an increase by 20% the number of citizens to be cared for by community clinics; an increase in federal funding by $7,000,000; and a more equitable distribution of state support to community agencies most in need.

The Mental Health Code

The Governor's Commission for Revision of the Mental Health Code of Illinois was appointed in late 1973, and charged with responsibility for recommending revisions to the laws, both civil and criminal, dealing with the mentally ill and developmentally disabled. The Illinois Department of Mental Health, continually concerned with the rights of patients, urged Governor Dan Walker to select a group of outstanding professional and lay persons to write a new Code—the first fundamental revision in almost ten years—to help guarantee Illinois citizens, especially children, early access to adequate and humane treatment while preserving their civil rights and liberties. The 32-member Commission, chaired by Cook County Circuit Court Judge Joseph Schneider, will submit its first report to the Governor by December 1, 1974.

The Closure of Peoria State Hospital

The Department engineered the phase-out of an obsolete facility in such a way as to attract national recognition as the model for the elimination of a no longer needed institution.

Peoria State Hospital was closed for three reasons: an antiquated, rundown physical plant requiring $6 million expenditure to meet national accreditation standards; a declining patient census (less than 600 patients in a 60-building complex); the availability of alternate, more modern community and Department of Mental Health facilities within the region.

The Department approached the phase-out with a rational and human concern for the needs of patients and employees. Two relocation task forces were created.

The Task Force on Patient Relocation set up timetables for the transfer of patients singly and in program groups to Galesburg State Research Hospital and Zeller Zone Center, Peoria. An exhaustive psychiatric profile of each patient was prepared. Patients were taken to visit their new quarters a month in advance. Relatives were consulted and kept thoroughly advised. The actual transfers of patients proceeded smoothly over a period of many months without incident.

The Task Force on Relocation of Employees helped workers find new jobs. Direct care employees were offered the chance to transfer with their clinical program. The Department paid all moving expenses, one-day travel funds to visit the new location, 15-days lodging and meals to find new housing.

For those employees who could not or did not wish to transfer, every attempt was made to find employment for them in the community, at other Department of Mental Health facilities or at other state agencies. Employees were allowed time off and travel expenses for interviews and test taking in other parts of the state.

Peoria State Hospital closed officially December 18, 1973. Of the 671 employees on the payroll on September 15, 1972, when the phase-out first began, 238 transferred or found related positions; 61 persons retired; 150 resigned; four were discharged; and 218 were terminated.

Adults

Adults account for more than 82% of admissions to Department of Mental Health facilities. Of these, almost 2,000 or 13% are geriatric admissions. Thus, adults from the age 18 to 65 and older are the primary consumers of mental health services and are the chief beneficiaries of better organized and better funded Department programs.

The total inpatient population at the state's 26 mental health facilities is slightly more than 15,000. As of June 30, 1968, the patient population numbered more than 30,000. This dramatic 50% reduction illustrates the continued build up of a comprehensive community-based system of delivering mental health services. Nearly 75,000 adults in all age groups were served in state aided clinics. More than 1,100 persons were given care and treatment at approved general hospitals with psychiatric units under the Department's purchase care program.

More than $45.0 million has been allocated by the state for grants and care purchased from community programs. Approximately 90% of the Department's total

budget is earmarked for the support of state-operated facilities, but a concerted effort by the Department to move away from institutional care toward care and treatment in community-based facilities indicates the future.

Children and Adolescents

Efforts were made toward making the institutions an integral part of the total network of mental health services for children. There were increased efforts toward normalization in which clinical services support the child remaining in his normal system, the family, school and community.

There was increased coordination and collaboration with other departments, namely Children and Family Services, the Department of Corrections and the Office of the Superintendent of Public Instruction, which included both formal agreements and liaison.

The role of the Department of Mental Health has been to supplement and support the school and pupil personnel services in those areas where mental health expertise is needed.

The Department provided educational services, supplemented by P.L. 89-313 Title I funds; in FY-73, this amounted to $1,405,550 serving over 1,500 children.

Developmental Disabilities

This Division experienced the most significant change in its history with the naming of a Deputy Director and an extension of its responsibilities for programs of service to persons suffering from epilepsy and cerebral palsy.

During the past year, 105 community agencies received a total of $12,377,972 to provide day treatment services for 9,609 clients in programs for the retarded across the state. Basically, clients in these programs reside in the community and use privately operated facilties. Last year, $10,208,232 was expended to 101 agencies offering service to 8,557 clients.

Programs for the adult retarded in community settings gained with the expansion of an add-on program for privately operated shelter care facilities. Thirteen facilities were approved for 959 placements and by June 30, 1973, there were 448 adult retarded enrolled in their residential training programs.

The Community Living Facility (CLF) Program was expanded from four to seven facilities with 100 individuals in programs designed for residential training for mildly and moderately retarded adults.

The Developmental Disabilities Services and Construction Act (Public Law 91-517) is administered in Illinois by this Division and in an 18-month period that spanned this annual review, the Division made 100 grant awards of $1,731,687 for community based service programs, $133,248 for construction of new facilities and $187,646 for planning purposes. It is preparing a state plan for 1974 in conjunction with the Governor's Council on Developmental Disabilities.

At the same time, the two largest state residential facilities, at Dixon and Lincoln, continued to reduce resident populations with Dixon dropping from 2,569 residents to 2,324 and Lincoln reducing from 2,286 to 2,090.

Construction continued on two new facilities to be located at Tinley Park and Waukegan. Both will offer services to 400 residents. The William A. Howe Center will be completed in spring, 1974 with the Waukegan Center projected for completion in the fall of 1974.

Drug Abuse

The Illinois Drug Abuse Program (IDAP) marked its fifth year of operation in 1973. More than 10,000 persons have voluntarily applied for treatment since the program's beginning in 1968.

By the end of FY-73, more than 4,300 persons were being served in 46 treatment centers throughout Illinois. IDAP expanded rapidly during its first five years and now offers a wide range of counseling services for all types of drug dependence problems. Centers for young drug abusers were expanded during 1973. A variety of treatment centers are now provided, ranging from therapeutic communities to residential and out-patient centers.

Funding for the Drug Abuse Program, through the Department of Mental Health, was approximately $7 million for FY-73. Federal monies in grants and contracts for specialized services totaled about $800,000 ($220,000 for an OEO Community Assistance Project and a $680,000 NIMH contract for expanded services at 11 existing clinics).

In March 1973, IDAP Director, Edward C. Senay, M.D., presented a comprehensive evaluation of the program's work entitled, "IDAP-Five Year Results" at the Fifth National Conference on Methadone, Washington, D.C. Additionally, the Illinois Drug Abuse Program was one of three throughout the United States selected for inclusion in the Stephen S. Wilmarth and Auram Goldstein, M.D., report to the World Health Organization in November, 1973.

Alcoholism

The state has been working for a year now to encourage and help Illinois industry set up employee alcoholism programs.

Prior to July 1, 1973, only eight companies had employee alcoholism programs. This is out of a total of 70,000 companies in the state. These 70,000 companies employ over 4,000,000 people.

It is estimated that 5% of these employees are alcoholics and an additional 5% are alcohol abusers, which adds up to 400,000 employees whose work life and/or family life are adversely affected by alcohol.

Seven new companies have started programs; six are in the development stage and three are giving serious consideration to getting started.

Local and state government employees will also benefit from Department alcoholism programs. Illinois has more than 400,000 full-time state and local governmental employees. Based on the formula that 5% of these employees are alcoholics and an additional 5% are alcohol abusers, it is estimated there are 44,000 non-federal government employees in Illinois who are alcoholics or alcohol abusers. The State of Illinois itself is a major Illinois employer with 120,000 workers.

The Department of Mental Health has approximately 20,000 employees—more than any other Code Department of the State of Illinois. It has also been designated as the single alcoholism authority for the state. It has seven regional offices (and numerous subregion offices) throughout the state, each with a Regional Alcoholism Coordinator, and as qualified personnel can be found, each region will have a Government Employees Alcoholism Occupational Coordinator as well.

Research and Development

In 1973, the Research and Development Program made several outstanding contributions to the services pro-

vided the Department of Mental Health's clients, and to the knowledge of biological and social conditions which may produce mental illness or mental retardation.

Immediate benefits to the Department of Mental Health clients in 1973 include new methods for the successful treatment of alcoholism, marital disorders and autistic self-stimulation. New methods have been tested successfully for a way to find jobs for ex-clients. There has been further improvement of procedures developed previously to teach self-help and self-control skills to the severely and profoundly retarded. A successful approach to the elimination of nervous tics and habits was developed.

International scientific and popular publications and the national news media have spotlighted the Department's clinical research achievements. These methods are types of learning-based therapies which are recognized as the most important advances in this field since the Department of Mental Health's pioneering work to develop the "token economy" system in the early 1960's.

The results of a number of research projects have been recognized as very important contributions to knowledge of clinical disorders. A group of Department of Mental Health scientists were given the Anna Monika Prize for research into psychiatry for their discoveries in the biochemical correlates of manic-depressive psychosis. Another group conducted studies which conclusively demonstrated that a widely publicized biochemical hypothesis for a cause of schizophrenia which originated in a famous East Coast laboratory was incorrect. The potential savings in research funds in closing off this false lead is very large.

In another program, the common food additive, monosodium glutamate, was shown to damage the brains of experimental animals. This discovery identifies a potentially toxic agent which might produce developmental disabilities.

University scientists on a research grant from the Department, using our patients, have discovered some suggestive relationships between abnormalities in the biochemical properties of skeletal muscle and psychoses, suggesting a common mechanism. There also is evidence from this work that the suspected disorder may be highly prevalent in some families.

LeRoy P. Levitt
Director

All members are urged to participate in the–

REFERENCE COMMITTEE MEETINGS

Wednesday, April 3, 1974 **7:00 p.m.**

Officers and Administration **Parlor 413**

Amendments to Constitution & Bylaws **Parlor 418**

Finances, Budgets and Publications **Parlor 419**

Governmental Affairs, Medical-Legal **PDR 2**

Education and Manpower **PDR 4**

Economics, Peer Review, Social and Medical Services **Beverly Room**

Public Relations, Membership and Miscellaneous Business **PDR 1**

Environmental, Community and Mental Health **Parlor 415**

Special Reference Committee No. 1 (Open Forum) **PDR 3**

Public Relations and Membership Services

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

During 1973, the Council on Public Relations and Membership Services sought to reduce expenditures for public and internal information programs, while diverting additional funds into projects which have been most productive, or show greatest promise for reaching our communications goals.

Radio-TV Speakers Bureau: A highly successful project was the revitalization of the Radio-Television Speakers Bureau, an activity begun at mid-year and carried out "on a shoestring." To date, nearly 100 physician speakers have agreed to represent ISMS on radio and television. Most of these reside or practice in Cook County, and initial efforts were expended to place speakers on Chicago TV and radio stations. By the end of 1973, 45 speakers had been placed and had logged 39 hours of air time. In addition, special projects such as placement of ISMS physicians on the University of Illinois's radio show, "Your Doctor Speaks," will result in 410 hours of broadcast time and throughout 1974. The program is syndicated to 49 radio stations in 19 states. Also, under plans made in 1973, ISMS expects to place ten speakers on the University of Illinois television show, "Consultation," which is carried by about 120 stations in 38 states. This will yield 600 hours of TV time during 1974. ISMS is assisting WGN-TV in placing Spanish-speaking physicians on a program directed toward the Latin population, and speaker-placement efforts outside Chicago have brought encouraging results.

Dr. SIMS Public Service Announcements: For many years ISMS had offered to Illinois radio stations a series of daily "health tips" presented by Dr. SIMS, the familiar symbol of ISMS health education projects. In previous years, 365 thirty-second tips were recorded on discs, then mailed to participating stations for broadcast over a three-year period. In 1973 an analysis indicated that this program, highly successful at its inception, was faltering and in need of a new format. Accordingly, thirty- to sixty-second radio "spots" about health care and socio-economic subjects were recorded on tape and mailed to 130 radio stations. Under the new format, topical public service announcements will be recorded every three months and mailed free of charge to participating stations. To date, station response to the new Dr. SIMS "Prescriptions for Your Health" has been encouraging.

Dr. SIMS Talks to Teens: The Council believed there was a need to review the long-standing newspaper feature, "Dr. SIMS Talks to Teens" which ISMS has offered to high schools and junior high schools for several years. In order to assure that the ten columns distributed for use during the 1974-75 school year will reflect the interests and concerns of teenagers, selected urban and suburban public and private schools will provide a panel of pupils to assist in developing appropriate subject matter and format. A second panel of school counselors, psychiatrists and pediatricians will provide professional expertise in preparation of the Dr. SIMS newspaper features.

Dr. SIMS Coloring Book: Several years ago a Dr. SIMS coloring book was proposed as a health-education tool for young children, but lack of funds delayed the project. The search continued for a grant to finance the book, and in December, 1973, Osco Drug Co. agreed tentatively to bear the cost of printing and distributing 50,000 copies to family physicians, pediatricians, psychiatrists, etc. Negotiations with Osco are continuing.

Members' Handbook: One of the major projects undertaken this past year was development of an attractive hardcover handbook to be presented to new members, replacing a bulky membership packet. The handbook is a three-ring binder with most information about services and benefits printed as page inserts, instead of pamphlets and brochures. The Council believes that a handbook will be of more value to physicians, since information will be handy for ready reference, and it will be simpler and more economical to update contents.

Legislative TV Activities: During past legislative sessions ISMS prepared and distributed a series of two-minute, sound-on-film interviews in which state legislators discussed health care legislation. Films were sent free of charge to five major downstate TV stations. A survey conducted this past year indicated that on-the-air use of the films did not justify the time or expense. The Council elected to drop this project in 1974. However, radio and TV interviews in which physicians and legislators discussed health care topics appear to benefit ISMS. This project will be continued, and if possible expanded during 1974.

President's Tour: The advent of PSRO and the appointment of Willard C. Scrivner, M.D., to HEW's National PSRO Council placed added significance upon this year's "President's Tour." His role on the Council enabled Dr. Scrivner to directly inform 16 county societies in 11 trustee districts of the latest PSRO developments in Washington as well as related ISMS action. The "tour" also was a vital tool in soliciting members' views on the controversial law and guiding ISMS efforts to formulate a unified, state-level PSRO.

Through interviews with newspaper, radio and television reporters, Dr. Scrivner filled an information gap by alerting the public to the potential perils posed to them by PSRO. Extensive media coverage focusing upon

Dr. Scrivner's 12-point "Physician's Bill of Rights" alerted the public to increasing government and other third-party interference with the traditional doctor-patient relationship.

District meetings held in conjunction with the "President's Tour" provided an opportunity for delegates and county society officers to confer with Dr. Scrivner and their trustees on matters of general concern to their constituents and problems peculiar to their areas.

Health Care "Hotline": Last May 15, at the suggestion of Willard C. Scrivner, M.D., President of ISMS, officers of ISMS and members of its Committee on Health Care of the Poor met with representatives of more than 40 community organizations, health agencies, volunteer groups and government agencies. The conference sought to identify major health and medical problems of the poor, and to explore ways in which problems could be alleviated or solved by the medical profession. Among major problems defined during the conference were lack of coordination of health/medical services and programs, and difficulties in making the poor aware of programs and services available to them. ISMS was urged to take the lead in coordinating and publicizing the wide range of available services. ISMS then began exploring ways in which an appropriate program could be developed. This led to a months-long dialog with the Council for Community Services in Metropolitan Chicago, an organization with long experience in operating a referral service which could be used as the base for a medical/health information service. Discussion with Council staff led to development of a joint proposal for operation of a 24-hour telephone "Hotline" which would provide medical and health information to callers throughout the metropolitan area. The Council hopes this service will be in operation by mid-1974.

Journalism Awards: This highly successful program, designed to honor outstanding achievement in medical journalism, marked its ninth anniversary in 1973. Seventeen winners, selected from among more than 130 radio, television and newspaper entries, received award plaques during the annual presentation banquet at the Sheraton-Chicago Hotel last May. Elaborate plans already are well under way for a gala dinner dance and awards presentation to mark the tenth anniversary of the competition. Some changes were made in 1973 categories to encourage wider participation by news media, and for the first time judging will be done outside Chicago. The Indianapolis Press Club has agreed to provide a panel of judges, and physicians named by the Indiana State Medical Association will assure medical accuracy of the winning entries.

Leadership Conference: The ISMS Leadership Conference on October 21, 1973, attracted additional media attention because of presentation of honorary membership in ISMS to Navy Capt. Joseph P. Kerwin, M.D., a member of the Skylab I astronaut crew. Capt. Kerwin, a native of Oak Park, Ill., and graduate of Northwestern University School of Medicine, was a guest speaker at the conference.

Other Activities: "Action Report" continued to be widely acclaimed as an outstanding medium for transmitting timely and vital socio-economic information to the membership. Demand continued for the ISMS pamphlet, *Medicare Misconceptions*, which explains Medicare benefits and limitations.

In addition, several new brochures and pamphlets promoting ISMS activities were produced during 1973.

Council

Lee F. Winkler, *Chairman*

Paul J. Biedenharn, *Vice Chairman* — Catherine L. Dobson
Sheldon Berger — Charles W. Pfister
Raymond H. Conley — Herbert Sohn
Karl T. Deterding — Alan Taylor

Consultants

Robert T. Fox — Philip G. Thomsen
Fredric D. Lake — Charles J. Weigel

Auxiliary Representative

Mrs. Donovan Stiegel

Physician Recruitment Program

During the past year 21 physicians found practice locations through the ISMS Physician Recruitment Program. Physicians were placed in Coal City, Fairfield, Chicago, Macomb, Pinckneyville, Seneca, Paw Paw, Streator, Normal, Springfield, Waukegan, Red Bud, Olney, Mt. Zion and Mattoon. Many of these communities are now enjoying the services of a family physician after years of unsuccessful recruiting.

The Third Annual Doctor's Job Fair was held on December 2, 1973, at the Sheraton O'Hare Hotel in Rosemont. Over 60 communities and clinics in urban, suburban and rural areas sent representatives to the fair to interview physicians looking for a place to practice. All physicians registered with the ISMS Placement Service, physicians taking the fall FLEX examination, and interns and residents in the Chicago area were invited to attend the fair. Unfortunately, the fair fell on the first Sunday that Illinois service stations were closed because of the gas shortage and attendance was somewhat smaller than that at previous fairs.

Full service of the Physician Recruitment Program includes the privilege of advertising in the *Illinois Medical Journal*. Currently, there are about 90 communities advertising in *IMJ* for physicians. These ads are sent monthly to an average of 50 interested physicians, and in turn their names are sent to the communities for follow-up. Listing of communities periodically is sent to all interns and residents in the State of Illinois.

Fifty-Year Club

Seventy-two physicians who graduated from medical school in 1923 were admitted to membership in the Fifty-Year Club during 1973. Total membership now is 625.

On March 27, 1973, 140 members and their families attended the Fifty-Year Club luncheon at the Conrad Hilton Hotel. Joseph Skom, M.D., Chairman, presented plaques and pins to new members. A musical skit was presented by the Chicago Chapter of the American Association of Medical Assistants, Illinois Society.

Visit the Exhibits

Social and Medical Services

COUNCIL ON SOCIAL & MEDICAL SERVICES

The Council on Social & Medical Services and its Committees expanded their activities during the year in several areas, particularly those involving rural health, health care of the poor, and emergency and disaster care. A Committee on Aging was re-established to meet government's growing concern in providing health care to the elderly.

The Council also was responsible for a special Ad Hoc Committee on Hospital Satellites that developed a policy statement reflecting ISMS' views on physician involvement in such facilities.

Highlights of the Council's activities during the year included:

- reviewing several hypertension screening programs for effectiveness in combatting problems of high blood pressure, particularly in inner city areas;
- proposing the development of a 24-hour telephone health "Hotline" that would provide information on health services to anyone via a central phone number;
- planning an educational nutrition conference for Outreach Workers to be held in Spring, 1974. The conference will be co-sponsored with the University of Illinois Extension Service;
- planning a health care program for migrant workers using a uniform health record system that would keep current records on health care given migrants throughout the state; and
- urging local physician participation in setting ambulance standards, determining ambulance service areas, and training emergency medical personnel.

In response to a request from the Secretary of State, the Council considered the question of putting medical information on Illinois drivers' licenses. The Council discouraged the state from adopting this plan.

The Council also is concerned with the growing number of weight clinics in the state, particularly those administering drugs to reduce weight. The Council plans to gather additional information on these clinics after which an ISMS position statement will be prepared for Board of Trustees' approval.

Other Council activities included preliminary investigation of "sex clinics" and health care delivery problems in the state's penal institutions. The Council plans to study both questions in further detail.

Council

James C. Reid, *Chairman*

John W. Bowden
Matthew B. Eisele
Kenneth A. Hurst
Robert P. Johnson
Max Klinghoffer
Carl C. Bell, *Intern-Resident*
Bertram B. Moss
Joel Rosen
Aaron M. Rosenthal
James W. Sutherland
Sheldon S. Waldstein
Paul Stromborg *SAMA*

Paul W. Sunderland, *Consultant*

Committee on Health Care of the Poor and Rural Problems

Aaron M. Rosenthal, *Chairman*

Paul W. Clark
Audley F. Connor, Jr.
Lawrence Hirsch
Harold A. Paul
Alphonso Robinson
Donald E. Stehr

Alfred D. Klinger

Consultants

Willard C. Scrivner
Fred Z. White

Mr. Gary B. Schwartz, *AMA*

Mr. Wali M. Siddiq, *Council on Science & Health Manpower Development*

Mr. Carmelo Rodriguez, *ASPIRA, Inc.*

Mrs. William Schowengerdt, *Woman's Auxiliary*

Committee on Emergency & Disaster Care

Matthew B. Eisele, *Chairman*

Max Klinghoffer, *Vice-Chairman*

Earl W. Donelan
Ralston R. Hannas, Jr.
William A. Hark
Stanley E. Ruzich

Consultants

Eugene P. Johnson
Allan L. Goslin

Aging Sub-Committee

Bertram B. Moss, *Chairman*

John W. Bowden
Kenneth A. Hurst

Robert P. Johnson

Ad Hoc Committee on Hospital Satellites

Sheldon S. Waldstein, *Chairman*

James W. Sutherland
John W. Bowden

Consultant

Samuel R. Cloninger

ILLINOIS DIVISION OF VOCATIONAL REHABILITATION

In retrospect the Illinois Division of Vocational Rehabilitation did well in FY '73. Although it functioned throughout the entire year without Congressional legislation and on funds set below that which was expected and far less than needed to meet rising costs and increasing demands for service, the results were in most respects gratifying.

The special projects for disabled Public Aid recipients took shape and began to move many of those served into jobs. As the year closed, the momentum was increasing rapidly. Public offenders received more than a fair share of our attention over the year, and those blind and visually handicapped clients coming to DVR for service numbered almost 5,000 of which 1,404 were rehabilitated, with over 2,500 continuing to receive further service. Vending stands operated by blind clients under the Randolph-Shepard Act increased by nineteen. This program, functioning through a cooperative arrangement with a nominee agency, the Visually Handicapped Managers of Illinois, is considered the most innovative program in the country.

Fiscal year '73 found 1,092 deaf and hard of hearing persons being provided extensive services and placed into jobs. Perhaps the most preeminent dependency-combating program DVR is engaged in is its Secondary Work Experience Program, in which high school students categorized as being vocationally handicapped are assisted in gaining marketable job skills. Over 4,500 youth participated in the program during FY '73.

New responsibilities are facing the agency in the ensuing year. The Social Security Disability Unit must phase out its Black Lung program and gear up to handle the Supplemental Security Income program recently enacted by Congress. Clients included in this program are disabled Public Aid recipients classified as permanently and totally disabled, aged and blind. Many of these will be referred to the general agency for rehabilitation services in the hope that they can be removed from the assistance rolls.

Congress and the White House became embroiled in a bitter battle of power politics using the Vocational Rehabilitation Act as the fulcrum. Two Acts were vetoed before a compromise was reached, but by this time the nation's disabled were national news. This could have advantageous effects if the disabled themselves continue to vocalize their demand to be involved.

On the brighter side, I firmly believe as long as there are disabled there will be efforts made and funds provided for their rehabilitation. It is up to the disabled themselves and the professionals engaged in the services-delivery system to make sure that the transformation from what is now to that which is new is the result consideration of, and the active involvement of, the disabled of our nation.

Alfred Slicer,
Director

All members are urged to participate in the

Reference Committee Meetings

Wednesday, April 3, 1974

7:00 p.m.

Membership, Public Relations, Miscellaneous Business	PDR 1
Governmental Affairs & Medical-Legal	PDR 2
"Open Forum"	PDR 3
Education & Manpower	PDR 4
Officers & Administration	Parlor 413
Economics, Peer Review	Beverly Room
Environmental, Community & Mental Health	Parlor 415
Constitution & Bylaws	Parlor 418
Finances, Budget, & Publications	Parlor 419

Resolutions

Resolution 74A-1

Introduced by: William M. Lees, for the Board of Trustees

Subject: Continued Funding for Illinois Council on Continuing Medical Education

Referred to: Reference Committee on Finances, Budgets and Publications

WHEREAS, The House of Delegates in 1971 recognized the growing need of and demand for continuing medical education by authorizing establishment of the Illinois Council on Continuing Medical Education, a unique organizational approach that unites the energies and resources of ISMS, Illinois physicians, and the State's medical schools; and

WHEREAS, The House expressed its full support for the ICCME concept by alloting for the Council's use, half ($10) of the 1972 and 1974 AMA-ERF assessment as start-up funds, and further in 1973 voted that ISMS should "support the activities of the Illinois Council on Continuing Medical Education to the extent authorized by this House of Delegates;" and

WHEREAS, Since entering operational status by appointing staff on September 1, 1972, ICCME has moved vigorously to supply much-needed learning services to Illinois physicians, among which these deserve special mention: the first Illinois Congress on CME, *Your Personal Learning Plan,* the individualized CME Calendar Service, CME workshops, and essential staff work of high quality in fulfillment of the Illinois CME Accreditation Program; and

WHEREAS, In its brief history, ICCME has gained a national reputation, bringing credit to itself, the Illinois State Medical Society, and State's eight medical schools; and

WHEREAS, ICCME's work over the past year has revealed the full extent to which Illinois physicians' learning needs continue to grow, making plain in turn the need for continued detailed exploration and planning of services, activities which do not produce income, therefore be it

RESOLVED, That half ($10) of each member's 1975 AMA-ERF contribution be allocated to the Illinois Council on Continuing Medical Education for use in activities as determined by the ICCME Board of Directors during and after the calendar year 1975.

Resolution 74A-2

Introduced by: William M. Lees, Chairman, Board of Trustees

Subject: Smoking in Hospitals

Referred to: Reference Committee on Environmental, Community and Mental Health

WHEREAS, Cigarette smoking has been shown to be at the center of vast vascular and pulmonary disease epidemics, and

WHEREAS, Hospitals are centers of health education and disease prevention as well as health restoration, and

WHEREAS, Cigarette smoking not only causes illness, but it retards healing and prolongs convalescence, therefore, be it

RESOLVED, That the Illinois State Medical Society goes on record as being against the sale of cigarettes in hospitals in which its members attend, and be it further

RESOLVED, That the Illinois State Medical Society will work actively to make hospitals cigarette smoke-free.

Resolution 74A-3

Introduced by: Joseph R. O'Donnell, for the Committee on Constitution & Bylaws

Subject: Amendment to Bylaws Chapter I, Section 1H, In-Training Members

Referred to: Reference Committee on Amendments to Constitution and Bylaws

WHEREAS, The section of the bylaws dealing with in-training members does not specify that candidates must be members of a county medical society and the section includes other qualifications that are considered extraneous, therefore be it

RESOLVED, That Chapter I, Section 1H, In-Training Members, be amended as followed:

In-training members are persons who are medical school graduates, of good moral character and professional standing serving an internship or residency approved by the American Medical Association in the State of Illinois *and are members of a component medical society.* [Delete: They must be recommended for membership by two-members of this Society who are also members of the hospital staff where the candidate is in training.] Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

Resolution 74A-4

Introduced by: Joseph R. O'Donnell, for the Committee on Constitution & Bylaws

Subject: Amendment to Chapter I, Section II, Student Members

Referred to: Reference Committee on Amendments to Constitution and Bylaws

WHEREAS, The Board of Trustees has recommended the elimination of SAMA membership as a prerequisite for student membership in ISMS, and

WHEREAS, The existing wording of Chapter I, Section II, raises a question about direct membership, therefore be it

RESOLVED, That Chapter I, Section II, Student Members be amended as follows:

Student members are those who have been accepted for the second year or higher in an Illinois medical school, are [Delete: members of the Student American Medical Association] of good moral character, professional and academic standing and student members of a component medical society [Delete: where provision has been made for this class of membership].

Resolution 74A-5

Introduced by: Joseph R. O'Donnell, for the Committee on Constitution & Bylaws

Subject: Amendment to Chapter II, Section 1, Dues

Referred to: Reference Committee on Amendments to Constitution and Bylaws

WHEREAS, The American Medical Association has moved up its delinquency date from June 1 to April 30, it is necessary to amend the ISMS bylaws accordingly. Therefore, be it

RESOLVED, That Chapter II, Section 1, Dues, be amended as follows:

Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal,* which shall be at least fifty percent of the regular subscription price of the Journal. Only Regular, Provision, Associate, In-Training and Student Members shall be assessed annual dues. The dues shall be paid by the component society for its members prior to [Delete: May 1] February 1 of each year.

Resolution 74A-6

Introduced by: Joseph R. O'Donnell, for the Committee on Constitution & Bylaws

Subject: Amendment to Chapter II, Section 2, Reduction and Remission of Dues

Referred to: Reference Committee on Amendments to Constitution and Bylaws

WHEREAS, Academic physicians are allowed a fifty percent reduction in dues upon recommendation of their county society, and

WHEREAS, This accommodation has not been useful for recruiting academic members, therefore be it

RESOLVED, That Chapter II, Section 2, Reduction and Remission of Dues be amended as follows:

[Delete: The Board of Trustees, upon recommendation of the component society, shall give fifty percent reduction in dues to teaching, research and administrative personnel in full-time employment in the approved medical schools of Illinois, or in similar net-for-profit institutions in Illinois]. Physicians in private practice of medicine may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half of the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases, the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Resolution 74A-7

Introduced by: Barry Seng, Delegate, for the Will-Grundy County Medical Society

Subject: Chiropractic

Referred to: Reference Committee on Governmental Affairs and Medical-Legal

WHEREAS, Chiropractors are licensed under the Illinois Medical Practice Act, and

WHEREAS, There are separate examining boards for dentists, nurses, optometrists, pharmacists, physical therapists, podiatrists and psychologists, and

WHEREAS, The Illinois State Medical Society does not support the theories of chiropractic, and

WHEREAS, Physicians sitting on a board that examines chiropractors implies support of chiropractic, therefore be it

RESOLVED, That the House of Delegates instructs the appropriate ISMS council or committee to develop legislation that would create a chiropractic examining committee and, be it further

RESOLVED, That this legislation would specify that physicians and surgeons licensed to practice medicine in all of its branches would not serve on this chiropractic examining committee.

Resolution 74A-8

Introduced by: A. J. Kiessel, Delegate, for the Macon County Medical Society

Subject: Arbitrary Actions of Food and Drug Administration

Referred to: Reference Committee on Governmental Affairs and Medical-Legal

WHEREAS, The Food and Drug Administration, particularly in the area of pharmaceutical drug recalls and restrictions, has taken actions which appear arbitrary and, in some instances, even capricious; and

WHEREAS, The actions and decisions of the Food and Drug Administration have resulted in the recall of pharmaceutical preparations that are in daily use; and

WHEREAS, This recall is done without adequate or, perhaps, without any consultation with a significant number of physicians who are in daily contact with people suffering from various illnesses and symptoms for which they appeal to the physician for relief; and

WHEREAS, These practicing physicians have not been polled, nor has their opinion been solicited in any significant degree, to determine their knowledge and informed awareness of the effectiveness and/or the safety of many pharmaceutical agents; and

WHEREAS, These arbitrary actions, taken without consultation with practicing physicians, constitute material interference with the practice of medicine, particularly that practice involving the use of pharmaceutical preparations for relief of illnesses; and

WHEREAS, This interference has resulted in diminishing the ability of the practicing physician to provide relief, alleviation or removal of symptoms that are many times of disabling degree; and

WHEREAS, This intrusion on physicians' decisions regarding pharmaceutical agents has thus injured patients generally and, in some instances, distinctly increased the cost of pharmaceutical relief available to patients as well as, in some instances, rendering it difficult or impossible for patients to obtain relief for which they appeal to physicians; and

WHEREAS, Practicing physicians who are in daily confrontation with illnesses might provide very valuable and useful information regarding the effectiveness and/or safety of a large number of pharmaceutical preparations that have, or are, or may come under the scrutiny of those members of the Food and Drug Administration who are concerned with this problem, therefore be it

RESOLVED, That the Illinois State Medical Society, through its delegation to the American Medical Association, request the AMA to seek appropriate legislation which would require the Food and Drug Administration to avail itself of the large amount of accessible information possessed by practicing physicians regarding pharmaceutical preparations before it arrives at decisions affecting the availability of pharmaceutical agents currently in use for the treatment of human illness.

Resolution 74A-9

Introduced by: Antonio Boba, Delegate, for the Jefferson-Hamilton County Medical Society
Subject: Election of American Medical Association Delegates and Alternate Delegates
Referred to: Reference Committee on Amendments to Constitution and Bylaws

WHEREAS, The present composition of the delegation of the Illinois State Medical Society to the American Medical Association's House of Delegates does not represent adequate geographical physician representation; and

WHEREAS, The geographical location of physician's practices create special and unique problems, which solutions require adequate and proper representation; and

WHEREAS, The present Illinois State Medical Society's Constitution and Bylaws provision for election of American Medical Association delegates and alternates does not provide for a geographical distribution of delegates, terms of office, number of terms, or any other qualifications, therefore be it

RESOLVED, That the Constitution and Bylaws Committee of the Illinois State Medical Society be directed to prepare changes in the Illinois State Medical Society's Constitution and Bylaws, which changes shall provide for a geographic distribution for the election of American Medical Association delegates and that there be a limit set as to their terms of office, and be it further

RESOLVED, That the Constitution and Bylaws Committee of the Illinois State Medical Society be directed to present such proposals to the House of Delegates of the Illinois State Medical Society at its annual meeting in 1975.

Resolution 74A-10

Introduced by: Julian W. Buser, Delegate, for the St. Clair County Medical Society
Subject: Abortion Policy
Referred to: Reference Committee on Officers and Administration

WHEREAS, Legality and ethics are not synonymous terms; and

WHEREAS, The Illinois State Medical Society is opposed to the concept of "abortion on demand;" and

WHEREAS, The physicians of this state do not feel that the ethics of the profession should be dictated by legal pronouncements of state or federal governments; and

WHEREAS, Even though physicians of the State of Illinois recognize that abortions performed within the provisions of the statutes of our state are to be considered legal, this legality does not necessarily equate with the long-standing ethic of the medical profession; therefore be it

RESOLVED, That the Illinois State Medical Society reaffirm its stand and policy regarding abortion as stated on Page 16 of the Illinois State Medical Society 1972-1973 Policy Manual, to wit:

"The Illinois State Medical Society is opposed to induced abortion except when under the following conditions:

1. There exists documentation of a severe threat to the health or life of the mother, or
2. There is documented medical evidence that the conceptus may be born with incapacitating physical or mental abnormality, or
3. There is documented evidence that continuation of a pregnancy resulting from statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient, and
4. Two other physicians chosen because of their recognized professional competence have examined the patient and concurred in writing, and
5. The procedure is performed in a hospital legally licensed and approved by the State of Illinois for the care of maternity patients."

Resolution 74A-11

Introduced by: H. Frank Holman, Delegate, for the St. Clair County Medical Society
Subject: Amendment to U.S. Constitution
Referred to: Reference Committee on Governmental Affairs and Medical-Legal

WHEREAS, The American Medical Association and its constituent societies have historically been leaders in promoting the passage of legislation to safeguard the life of the unborn; and

WHEREAS, The Supreme Court of the United States has struck down the laws enacted by the various states in defense of the life of the unborn; and

WHEREAS, This act has been interpreted as a mandate for the adoption of laws permitting abortion on demand; and

WHEREAS, These laws are intended to solve social problems by the use of medical means which violate the fundamental philosophy of the medical profession; therefore be it

RESOLVED, That the House of Delegates of the Illinois State Medical Society shall authorize and direct the Board of Trustees to initiate, or actively support, the implementation of an amendment to the Constitution of the United States which will provide that no human being, including the unborn, shall be deprived of life without due process of law, nor denied equal protection of the laws, and be it further

RESOLVED, That the ISMS delegates to the AMA House of Delegates be instructed to present and support this resolution to the House of Delegates of the AMA.

Resolution 74A-12

Introduced by: Warren D. Tuttle, Trustee, Ninth District
Subject: Billing for Ancillary Personnel Services
Referred to: Reference Committee on Economics & Peer Review & Social & Medical Services

WHEREAS, there is a need to clarify physician billing procedures and the propriety of itemizing such services for third party payors, and

WHEREAS, some physicians have itemized servicse performed by physician assistants and other ancillary personnel, therefore, be it

RESOLVED, that the ISMS delegation to AMA request the AMA to develop a policy statement as soon as possible regarding the billing for services performed by ancillary personnel employed by the physician.

Resolution 74A-13

Introduced by: H. Frank Holman, Delegate, St. Clair County Medical Society

Subject: Rescinding Abortion Policy

Referred to: Reference Committee on Officers and Administration

WHEREAS, Since the rise of civilization, the physician, in his role as healer and in the conduct of his profession, has dedicated himself to the preservation of human life in all stages of development; and

WHEREAS, The physician's persistant devotion to the preservation of human life has given the medical profession a heritage of dignity and honor; and

WHEREAS, The Supreme Court of the United States has overridden the laws enacted by the representatives of the people of the various states, in defense of the life of the unborn; and

WHEREAS, This act has been interpreted as a mandate for the adoption of laws permitting abortion on demand; and

WHEREAS, These laws are intended to solve social problems by the use of medical means, which violates the fundamental philosophy of the medical profession; and

WHEREAS, The physician is aware that the widespread and unrestricted destruction of innocent human life in any form can only weaken the barriers that civilization has evolved to safeguard all human life; and

WHEREAS, Statutes legalizing indiscriminate abortion have placed in conflict the precept of law and the concept of ethics, thereby creating a dilemma for the individual and for the medical societies of the various states; and

WHEREAS, The physician is not compelled by law to perform a medical act which is considered unethical, or which is contrary to good medical judgment; and

WHEREAS, In Western culture ethical concepts always have been accorded the highest esteem, and are not considered nullifiable by law; therefore be it

RESOLVED, That the Illinois State Medical Society House of Delegates shall go on record as affirming that medical ethics must never be subject to definition, regulation or compromise by law; and be it further

RESOLVED, That the House of Delegates of the Illinois State Medical Society rescind its action of March, 1973, which revised the society's policy on abortion by providing that an abortion not in conflict with state and federal law shall not be considered unethical; and be it further

RESOLVED, That the House of Delegates of the Illinois State Medical Society shall restore the policy position of the Illinois State Medical Society to one opposing induced abortion except for certain critical medical conditions, as printed in the society's 1972-73 Policy Manual, as follows:

1. There exists documentation of a severe threat to the health or life of the mother, or
2. There is documented medical evidence that the conceptus may be born with incapacitating physical or mental abnormality, or
3. There is documented evidence, that continuation of a pregnancy resulting from statutory or forcible rape or incent may constitute a threat to the mental or physical health of the patient, and
4. Two other physicians chosen because of their recognized professional competence have examined the patient and concurred in writing, and
5. The procedure is performed in a hospital legally licensed and approved by the State of Illinois for the care of maternity patients.

Resolution 74A-14

Introduced by: Joseph Skom, Trustee, Third District, for the council on Mental Health and Addiction

Subject. Medical Psychotherapy

Referred to: Reference Committee on Governmental Affairs & Medical Legal

WHEREAS, Many individuals with urging levels of compotency attempt to provide care for persons with mental, emotional and nervous disorders, said individuals including but not limited to psychologists, psychiatric social workers, marriage counselors; and such care is broadly termed "psychotherapy," with little or no recognition of medical problems or pathology; and

WHEREAS, Psychotherapy, and especially medical psychotherapy, is a treatment modality requiring the training, expertise and differential diagnostic ability of the doctor of medicine, to be utilized in the amelioration of illness, which should recognize the intertwining of psychological and physical elements of illness; and

WHEREAS, In the protection of public health and to guarantee that services provided in health care, particularly in mental health care, are in keeping with the medical model, and

WHEREAS, A specific definition of psychotherapy will help to have all citizens understand what psychotherapy is and who should utilize it, and will identify procedures legally recognized as the practice of medicine; therefore be it

RESOLVED, That the following definition of psychotherapy be endorsed for incorporation into ISMS policy,

Medical Psychotherapy

Psychological and physical components of an illness are inextricably intertwined. At any point in the illness, psychological symptoms may give rise to, substitute for, and run concurrently with physical symptoms; the reverse also may occur.

Effective dealing with this phenomena is done in the patient-physician interaction by a physician who has demonstrated a competence in psychiatric medicine. It may be done individually with a patient, or in a group setting with more than one patient. It is a medical procedure that is used to treat mental, emotional, and psychosomatic illness, and is a part of the practice of medicine.

It entails, always, continuing medical diagnostic evaluation and responsibility. The use of drug management and other necessary aids to accomplish treatment are used as medically indicated.

It may include psychoanalysis, insight oriented, behavior modifying, or supportive psychotherapy.

and be it further

RESOLVED, that appropriate terminology be suggested for the Medical Practice Act to state that psychotherapy must be under the direct control and supervision of a doctor of medicine.

Resolution 74A-15

Introduced by: David T. Petty, Delegate, for the Medical Legal Council

Subject: Confidentiality

Referred to: Reference Committee on Officers & Administration

WHEREAS, There have been various activities on the part of third-party carriers infringing upon the privacy of the physician/patient communication; and

WHEREAS, Various governmental proposals have been advanced to eliminate the confidentiality of patient communications; therefore be it

RESOLVED, That there be a reaffirmation of the principle of confidentiality, as follows:

"Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileges must be continued in accomplishment of the treatment of human illness. Section 9 of the Principles of Medical Ethics, states: 'A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community.' The Illinois State Medical Society reaffirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good."

Resolution 74A-16

Introduced by: Guy Pandola, Delegate, for the Council on Mental Health and Addiction

Subject: Alcoholism

Referred to: Reference Committee on Economics, Peer Review, Social & Medical Services

WHEREAS, Alcoholism continues to be a serious problem to the public and there may be a need for deeper understanding by some physicians; and

WHEREAS, There is a need to better identify and define alcoholism; and

WHEREAS, Alcoholism should be identified as an illness to be covered by health insurance policies; and

WHEREAS, Alcoholics often are incarcerated rather than treated, and some hospitals are reluctant to accept alcoholics for treatment; therefore be it

RESOLVED, That the following refined definition of alcoholism be adopted as an expression of official ISMS position, to wit:

"Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression; and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational, and/or social adjustments as a direct consequency of persistent and excessive use of alcohol;" and be it further

RESOLVED, That ISMS encourage insurance companies to include coverage for alcoholism in health insurance policies similar to coverage for any other illness; and be it further

RESOLVED, That general hospitals, both public and private, be encouraged to accept alcoholic patients (both inpatient and outpatient, for detoxification and rehabilitation) on the same basis as other patients, which encouragement should be accomplished by ISMS in cooperation with the Illinois Hospital Association.

Resolution 74A-17

Introduced by: Joseph Skom, Trustee, Third District, for the Council on Mental Health and Addiction

Subject: Limited License Physicians in State Hospitals

Referred to: Reference Committee on Education & Manpower

WHEREAS, Patients in state hospitals must receive optimum care; and

WHEREAS, Subsequent to World War II an influx of foreign-trained physicians resulted in utilization of those unable to obtain full licensure through a change in licensure laws to allow a limited license capacity in state hospitals, replacing those fully licensed who left to enter private practice; and

WHEREAS, Present Illinois law will eliminate the limited license state hospital permit doctor from state service as of June 30, 1975; and

WHEREAS, Additional time may be necessary to avoid emasculation of the state mental hospitals, possibly closing down at least half of them; and

WHEREAS, The Director of the Department of Mental Health and Developmental Disabilities has suggested a possible approach to this; and

WHEREAS, There is a recognition of a need to realistically working to continue service; therefore be it

RESOLVED, That the following procedure be suggested by ISMS as a course of action in resolving the difficulties being encountered with the "permit doctor" concept (which is a modification of the Director's proposal):

(A) Until January, 1978, non-licensed physicians would be permitted to enter state service only if

(1) they possess an ECFMG Certificate and have completed an approved internship or approved training program and

(2) they pass the State of Illinois medical licensure examination within 12 months of beginning their state service. If they are unsuccessful, they will be dismissed. With this stipulation, no more limited license physicians will enter the system.

(B) The present limited license group be given a clinical competency written and/or oral examination by the Department of Registration and Education and that upon passing they be given a hospital license to practice only in state mental hospitals.

Those that fail this examination will be dismissed from state service. Those that pass will be given a "Hospital License" to practice in state hospitals enabling them to continue their duties, subject to their periodic quarterly performance evaluation by clinical supervisors. (They will continue to be encouraged to take the state board examination for full licensure.) ; and be it further

RESOLVED, That ISMS encourage the IDMHDD to continue intensive recruitment of fully licensed physicians to meet the needs of the ill in state hospitals; and be it further

RESOLVED, That ISMS continue to support high quality care of uniform standard for all the citizens of Illinois.

Resolution 74A-18

Introduced by: David T. Petty, Delegate, for the Medical Legal Council
Subject: Arbitration of Medical Personal Injury Claims
Referred to: Reference Committee on Governmental Affairs & Medical Legal

WHEREAS, A sharp increase in malpractice claims filed against physicians in the past two years has been documented by data developed by professional organizations and professional liability insurance underwriters, with a resultant rise in liability insurance premiums; and

WHEREAS, Under the influence of the consumer movement there is a rising tendency for the public to seek redress for all sorts of harms, real or assumed; and

WHEREAS, The rise of specialization and increased practice of medicine in hospitals and clinics has diminished the personal relationships often established between physician and patient, often giving rise to patient dissatisfaction due to quality and quantity of information received; and

WHEREAS, The HEW Secretary's Commission on Malpractice has recommended more widespread use of arbitration experimentally as an alternative mode for resolving medical maloccurance disputes; and

WHEREAS, ISMS over the past five years, and the past two years in particular, has been developing various plans to ameliorate the increasingly important problem of malpractice suits, and has recently developed a Pilot Hospital Arbitration Program in conjunction with the Illinois Hospital Association and the Chicago Hospital Council, since most claimed injuries occur in hospital; therefore be it

RESOLVED, That ISMS encourage its members to pay heed to the need for good two-way patient communication as one method of alleviating the increasing incidence of malpractice suits; and be it further

RESOLVED, That there be continued exploration of fair, expeditious methods of disposing of health care liability claims, and a continued monitoring of the malpractice climate; and be it further

RESOLVED, That there be endorsement of and encouragement for arbitration as one means of addressing the problems encountered by claims of personal injury by health care providers; and be it further

RESOLVED, That the House endorse the concept and principle of the joint ISMS-IHA-CHC Pilot Project of Voluntary Arbitration of Professional and Institutional Medical Malpractice Claims, which includes the prompt, equitable, just and private settlement of a claimed injury, based on a positive option on the part of patient in accepting binding arbitration, with a 60-day revocation period, allowing not only monetary awards but additional therapy or rehabilitation when actual injury has occurred.

Resolution 74A-19

Introduced by: Joseph Skom, Trustee, Third District, for the Council on Mental Health and Addiction
Subject: Diagnosis and Length of Stay-Principles
Referred to: Reference Committee on Economics, Peer Review, Social and Medical Services

WHEREAS, Third party carriers and government programs do not render direct medical care and are not, therefore, directly cognizant of patient medical treatment requirements, and

WHEREAS, Rules and regulations requiring certification of need for treatment and attempts to limit length of treatment programs according to diagnosis, are not consonants with quality care; therefore be it

RESOLVED, That the following Statement of Principles of the relationship between diagnosis, prognosis and treatment, be adopted; and be it further

RESOLVED, That ISMS inform third party carriers and Government Program Directors of these, asking that they abide by these principles, lest quality care be diminished; and be it further

RESOLVED, That these principles be submitted by ISMS to the AMA House of Delegates.

Principles of the Relationship of Medical Diagnosis to Prognosis and Treatment

> Prognosis, as it pertains to the treatment response of illness, is never only a function of diagnosis. Multiple determinants of a physical, emotional and environmental nature are involved. Some of the variables influencing prognosis include duration and severity of symptoms and signs, patient, family and employer cooperation, patient and family psychopathology, variations in medication effects and side effects, patient motivation and application of his responsibilities and insights. Therefore exception is often the rule. A favorable prognosis does not mean a condition is mild. An unfavorable prognosis does not mean improvement is impossible.

Treatment goals entail not only modification of the manifest clinical symptomatology, but functional adjustments as well. Functional improvement in domestic, social, occupational and intra-psychic areas are basic to appropriate treatment efforts whether a patient has a cardiac, neuromuscular, surgical or psychiatric condition.

It follows therefore, that because of the many variables involved in prognosis and the multiple goals essential to adequate treatment, the length of treatment whether inpatient or out-patient can never be solely related to diagnostic category. Prognosis and treatment length must always be individualized to the patient rather than to the diagnosis.

Resolution 74A-20

Introduced by: William M. Lees, Chairman, Board of Trustees
Subject: Repeal of Anti-Substitution laws
Referred to: Reference Committee on Governmental Affairs & Medical Legal

WHEREAS, In the 1950s, various states, upon recommendation of the American Pharmaceutical Association, with its component state units and the support of medicine, suggested laws prohibiting substitution for a prescribed item; the terminology of the current Illinois Pharmacy Practice Act being as follows:

> "Nor shall any person being requested by means of a prescription, or in any manner, to sell, furnish, or compound any drug, medicine, poison, chemical or pharmaceutical preparation, substitute or cause to be substituted therefore, without prior notification to and consent of the purchaser in the absence of a prescription, or, without prior notification to and consent of the prescriber in the presence of a prescription, any other drug, medicine, chemical poison or pharmaceutical preparation provided that the dispenser may alter the prescription as to content or dosage form, only upon consent of the prescriber issuing the same."

and the current Illinois Food, Drug and Cosmetic Act which states:

"Dispensing or causing to be dispensed a different drug or brand of drug in place of the drug or brand of drug ordered or prescribed without the express permission of the person ordering or prescribing;" and

WHEREAS, Recently proposed HEW Regulations would require dispensing of drugs and pharmaceuticals for Medicare and Medicaid recipients at "the lowest cost at which the drug is generically available," thus effectively requiring substitution; and

WHEREAS, Physicians, where appropriate, *have* been prescribing the least expensive drug available, in keeping with good patient management, concern for idiosyncratic reactions in individual instances, prevention of iatrogenic events, as well as costs to patients; and

WHEREAS, Present antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, and do, in fact, encourage interprofessional communication regarding drug product selection while assuring each profession the opportunity to fully exercise its expertise in drug usage; and

WHEREAS, Repeal of antisubstitution laws is being proposed by several groups, and two bills already have been introduced in Illinois to permit brand name interchange or substitution unless the prescriber indicates otherwise in writing, and

WHEREAS, Repeal of antisubstitution laws could have a profound effect on the well-being of patients and does not guarantee that there will be a resultant savings in drug costs, while transferring responsibility for medical decisions to persons not authorized to practice medicine; therefore be it hereby

RESOLVED, That ISMS indicate support for continuation of present antisubstitution laws since there is no merit whatsoever in repeal and make appropriate comment to government agencies supportive of existing laws.

Resolution 74A-21

Introduced by: David T. Petty for the Medical Legal Council

Subject: Contingency Fees in Professional Liability Suits

Referred to: Reference Committee on Governmental Affairs Medical Legal

WHEREAS, The rising incidence of suits for medical maloccurrances is of great concern to the medical profession; and

WHEREAS, Many such suits entered are frivolous and nonmeritorious; and

WHEREAS, The present system whereby trial attorneys accept representation of plaintiffs and receive a fee contingent upon the successful outcome of the suit in favor of the plaintiff, which system increases the scope of award should an award be made, and which also increases the premiums on professional liability insurance increasing the cost of health care delivery; therefore be it hereby

RESOLVED, That ISMS investigate and develop alternatives that protect the patients' rights, as such relate to the contingency fee in suits for medical maloccurrances.

Resolution 74A-22

Introduced by: Joseph Skom, Trustee, Consultant for the Council on Mental Health and Addiction

Subject: Psychiatric overnight test home visits, reimbursement by Medicare

Referred to: Reference Committee on Economics, Peer Review, Social and Medical Services

WHEREAS, Overnight therapeutic test home visits often may be medically necessary in the treatment of psychiatric inpatients; and

WHEREAS, Overnight therapeutic test home visits are an appropriate means of active treatment in the rehabilitation and return of patients to the community from V. A. hospitals, state mental hospitals, general hospital psychiatric units and private psychiatric hospitals; therefore be it

RESOLVED, That Regulations 216.1 and 216.3 of the Health Insurance For the Aged Manual of the U.S. Department of Health Education and Welfare, Social Security Administration, which deny coverage for overnight therapeutic test home visit treatment measures to the elderly and disabled, be vigorously condemned as injurious and discriminatory and that Congressional leaders be requested to modify pertinent regulations of Medicare and other Federal Programs to allow coverage for therapeutic overnight test home visits for Psychiatric Inpatients.

Resolution 74A-23

Introduced by: Guy Pandola, Delegate, for the Council on Mental Health and Addiction

Subject: Alcoholism Education

Referred to: Reference Committee on Education & Manpower

WHEREAS, Alcoholism is a greatly misunderstood illness; and

WHEREAS, Better education of medical and health care personnel and the public could help to modify problems of recognition and treatment of alcoholism; and

WHEREAS, Enlargement upon existing programs furnishing education and service to alcoholics and their families could help to provide more services in the treatment of alcoholics; therefore be it

RESOLVED, That ISMS recommend to Illinois medical schools and hospital training programs that there by expanded instruction of students in the treatment of alcoholism, as well as its cause and prevention, as such relate both to acute episodes and chronic dependency; and be it further

RESOLVED, That there be encouragement for mental health clinics to enlarge services to include treatment of alcoholics and counseling for families of alcoholics, and where appropriate in collaboration with Alcoholics Anonymous as well as half-way houses; and be it futher

RESOLVED, That ISMS encourage educational programs aimed at current alcohol abusers who are drivers, and where such education is not accepted by the alcohol abuser, there be support for legal restrictions against the opportunity to hold a driver's license (although this sanction should not maintain against rehabilitated alcohol abusers) ; and be it further

RESOLVED, That ISMS encourage programs of education for the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects.

Resolution 74A-24

Introduced by: Guy Pandola, Delegate, for Council on Mental Health and Addiction

Subject: Misuse of Medical Prescriptions

Referred to: Reference Committee on Public Relations, Membership and Miscellaneous Business

WHEREAS, Recent investigations by the Illinois Legislative Investigating Commission have identified some physicians who engage in the writing or selling of prescriptions for drugs of abuse to drug misusers, which results in drugs becoming available in the street market, thus reflecting upon all physicians; and

WHEREAS, Current mechanisms delay action against physicians misusing medical prescriptions or do not allow action against such physicians; and

WHEREAS, The endemic problem of drug misuse is of serious concern to society and particularly the medical profession, and medicine should take steps to eliminate drug misuse as far as possible, and should suggest possible solutions to this problem; therefore be it

RESOLVED, That the misuse of medical prescription by physicians to contribute to drug abuse be redeclared as unethical; and be it further

RESOLVED, That all physicians be alert to misuse of prescriptions by physicians and be encouraged to report instances of misuse to their county medical society ethical relations committee; and be it further

RESOLVED, That county medical societies be encouraged to report documented instances of misuse of medical prescriptions to ISMS, and to the Department of Registration and Education for disciplinary action as provided in Section 16, reason 4, of the Medical Practice Act; and be it further

RESOLVED, That the Committee on Physician Competence be encouraged to develop appropriate medical disciplinary legislation with the utmost speed.

Resolution 74A-25

Introduced by: E. K. DuVivier, Delegate
Subject: Approval of EPSDT MEDICHEK Program
Referred to: Reference Committee on Economics, Peer Review, Social and Medical Services

WHEREAS, We believe in the value of periodic health evaluation of children (well baby check-ups); and

WHEREAS, We believe that all the children in Illinois should be given an opportunity for optimal physical, intellectual and emotional growth; and

WHEREAS, We agree that some of these children should receive recommended services out of general tax funds if they truly cannot afford to pay for them in any other way (bonafide indigents); and

WHEREAS, Excellence of medical care is ultimately determined by the competence, the motivation and the integrity of the physician who provides it; therefore be it

RESOLVED, That the 1974 ISMS House of Delegates approves the concept of the EPSDT MEDICHEK Program if:

1. Payments conform to the current usual and customary fee range of area.
2. The program cannot come into an area without the yearly approval of the local county medical society and the participation of 50 percent of the local physicians.
3. The EPSDT Program shall be under the direct control of the Peer Review and the Ethical Relations committees of the local county medical society for each service area involved with the usual established privileges of appeal.

Resolution 74A-26

Introduced by: William B. Frymark, for the DuPage County Medical Society
Subject: Blue Shield Program
Referred to: Reference Committee on Economics, Peer Review, Social and Medical Services

WHEREAS, The Blue Shield program was originally designed and operated by physicians; and

WHEREAS, During recent years physicians have gradually lost control of this program, which is now operated by lay people and it is no longer supported by the majority of physicians in Illinois; and

WHEREAS, The Blue Shield plan is still advertised as "The Physicians' Own Plan," therefore be it

RESOLVED, That the Illinois State Medical Society inform the public that the Blue Shield program is no longer the "Physicians' Own Plan;" and be it further

RESOLVED, That the Blue Shield Plan be informed that the physicians of the Illinois State Medical Society no longer sanction the program; and be it further

RESOLVED, That the Blue Shield Plan be prohibited from advertising itself in any way as "The Physicians' Own Plan."

Resolution 74A-27

Introduced by: Alfred Klinger, Delegate
Subject: Delayed Reimbursement by Illinois Department of Public Aid
Referred to: Reference Committee on Governmental Affair & Medical-Legal

WHEREAS, People on public assistance, because of low income, poor housing, food, clothing, and education, have the greatest number of illnesses per capita of any segment of our population; and

WHEREAS, There is a great shortage of physicians in low income areas through the state; and

WHEREAS, The Illinois State Medical Society is aware of this problem and wishes to correct it; and

WHEREAS, The Illinois Department of Public Aid has done little to attract physicians into low income areas; and

WHEREAS, The Illinois Department of Public Aid has a persistent and consistent policy of not paying physicians for their services for many months and often years; and

WHEREAS, Physicians must continue to cover their high office expenses despite this lack of payment; therefore be it

RESOLVED, That the Illinois State Medical Society reaffirm it past stand that physicians be reimbursed within two months from the time bills are submitted; and be it further

RESOLVED, That if reimbursement is not forthcoming by the beginning of the third month following billings, then the Illinois Department of Public Aid will be charged one and one-half (1½) percent interest on the unpaid balance; and be it further

RESOLVED, That this resolution be implemented by ISMS seeking appropriate legislation and actively working for its passage.

Resolution 74A-28

Introduced by: Gerald J. Liesen for Kane County Medical Society

Subject: Honorariums for President, President-Elect and Chairman of the Board of Trustees

Referred to: Reference Committee on Finances, Budgets and Publications

WHEREAS, The Illinois State Medical Society continues to need professional and able guidance; and

WHEREAS, The President of the Illinois State Medical Society must be well a qualified physician, usually in private practice; and

WHEREAS, A great deal of time is required of the President, President-Elect and Chairman of the Board of Trustees of the Illinois State Medical Society to conduct Society affairs properly; and

WHEREAS, They thereby sustain loss of income in carrying on Society functions; therefore be it

RESOLVED, That the Illinois State Medical Society compensate the President, President-Elect and the Chairman of the Board of Trustees annually with an appropriate honorarium; and be it further

RESOLVED, That these funds be made available from the AMA-ERF fund at the approximate rate of $3.00 per dues paying member.

Resolution 74A-29

Introduced by: George J. Shimkus for Kane County Medical Society

Subject: Excessive Control of Physicians' Fees

Referred to: Reference Committee on Economics, Peer Review, Social and Medical Services

WHEREAS, The record will show that physicians' compliance with wage and price controls was unsurpassed by any other economic group; and

WHEREAS, The fee-for-service system of health care delivery serves the interests of most patients and most physicians in a mutually satisfactory manner; and

WHEREAS, Continued excessive free control of physicians' income where their overhead costs are uncontrolled produces an inequity; and

WHEREAS, Such inequity will inevitably lead to a deterioration in medical care to the detriment of the patient; therefore be it

RESOLVED, That this House of Delegates express its support of the AMA in its vigorous requests to COLC to remove control of physicians' fees.

Resolution 74A-30

Introduced by: Wayne N. Leimbach for Kane County Medical Society

Subject: Physician's Federal Narcotic Numbers

Referred to: Reference Committee on Governmental Affairs and Medical-Legal

WHEREAS, It is the just function of Government to legislate for the public safety and welfare; and

WHEREAS, It is the just function of the ISMS to see that such legislation is appropriate and in keeping with sound medical practice and the public interest; and

WHEREAS, The Congress did in haste and crisis atmosphere legislate changes in narcotic controls with questionable attention to administrative details in 1970; and

WHEREAS, The Executive Department of Government did establish new narcotic numbers for Physicians having nine digits (two letters and seven Arabic numbers) creating, at best, inconvience and recall problems for most of the practicing physicians in the United States; and

WHEREAS, The Executive Branch of Government continues to compound these inconviences by demanding greater use of these numbers for yet less appropriate indications; and

WHEREAS, The problems of narcotic abuse and drug abuse in the United States by and large do not arise from the prescribing habits of the practicing physicians; and

WHEREAS, The Illinois State Medical Society did approve this resolution in 1973 and presented it to the House of Delegates of the AMA; and

WHEREAS, The reference committee of the AMA did sympathize ". . . with those physicians who find . . . the new BNDD registration numbers onerous . . ." but did direct itself to the cost of changing the system rather than to the continuing inconvenience to physicians and the continuing cost of this inconvenience; and

WHEREAS, The House of Delegates of the AMA did but by narrow margin sustain the reference committee in the rejection of this resolution in 1973; therefore be it

RESOLVED, That the ISMS through its delegates to the House of Delegates of the AMA stimulate and nurture the awareness of that house to the everyday problems of the least of its members and its responsibility to assist its members with problems so small as this; and be it further

RESOLVED, That the ISMS, through its Representatives in the House of Delegates, and the AMA, through its Legislative Representatives to the Congress, institute such action as to correct this unnecessary inconvenience to the practicing physicians, to institute a system of narcotic regulation numbers consisting of three letters and four, and no more than five, Arabic numbers, to assist the practicing physician in a more efficient and less disruptive pursuit of his practice.

Program Summary By Days

(Preliminary)

Tuesday
April 2, 1974

8:00 a.m.	IFMC Membership Meeting
1:00 p.m.	ISMS Board Meeting

Wednesday
April 3, 1974

8:00 a.m.	Delegate Registration
8:00 a.m.	Exhibits Open
9:00 a.m.	Socio-Economic Program
10:00 a.m.	ISMS District Caucuses
3:00 p.m.	House of Delegates
5:30 p.m.	Delegates Buffet
7:00 p.m.	Reference Committees
	Open Forum
	Constitution & Bylaws
	Officers & Administration
	Finances, Budgets & Publications
	Governmental Affairs & Medical Legal
	Education & Manpower
	Environmental, Community & Mental Health
	Economics, Peer Review, Social & Medical Services
	Public Relations, Membership & Miscellaneous Business

Thursday
April 4, 1974

7:45 a.m.	ISMS Board Meeting
8:00 a.m.	Registration Opens
8:00 a.m.	Exhibits Open
9:00 a.m.	Symposium on Nutrition
12:00 noon	Nutrition Luncheon
1:30 p.m.	Interns/Residents Meeting
1:30 p.m.	ICCME Workshop
6:00 p.m.	ISMS President's Dinner

Friday
April 5, 1974

8:00 a.m.	Public Affairs Breakfast
8:00 a.m.	Registration Opens
8:00 a.m.	Exhibits Open
8:30 a.m.	Medical-Legal Program
11:00 a.m.	50-Year-Club Luncheon
2:00 p.m.	House of Delegates
1:30 p.m.	Drug Abuse Program
5:00 p.m.	IMPAC Annual Meeting

Saturday
April 6, 1974

8:00 a.m.	Registration Opens
8:00 a.m.	ISMS Board Meeting
8:00 a.m.	SAMA Student Program
9:00 a.m.	House of Delegates
6:00 p.m.	Board of Trustees Dinner

Physicians and Auxilliary of

the Illinois State Medical Society

are cordially invited to a gala

President's Night

7:00 pm Dinner

April 4, 1974

Grand Ballroom

Conrad Hilton Hotel

Cocktails 6:00 pm

Compliments of INTRAV

Doctor's News

LEGISLATIVE DAY IN SPRINGFIELD SLATED MAY 22—Physicians and Auxiliary of the Illinois State Medical Society are asked to participate in the first ISMS Legislative Conference, to be held May 22, 1974, at the Ramada Inn, Springfield. During the day there will be discussion of current health care issues; a slide presentation—"The Legislation Process;" a panel discussion on "Medical Involvement in the Political Process;" preview of the 1974 elections; an IMPAC presentation and a reception for legislators.

AMA INITIATES ACTION AGAINST COST OF LIVING COUNCIL—On February 6, James H. Sammons, M.D., Chairman of the AMA Board of Trustees, announced the Board's decision to initiate legal action against the Cost of Living Council to remove mandatory wage and price controls on physicians. The suit will challenge the validity and protest the discriminatory aspects of such controls.

FAMILY PRACTICE BOARD EXAM IN OCTOBER—The American Board of Family Practice announces that it will give its next two-day written certification examination on October 19-20, 1974. It is necessary for each physician desiring to take the examination to file a completed application with the Board office; applications must be received by June 15, 1974.

Interested physicians should write: Nicholas J. Pisacano, M.D., American Board of Family Practice, University of Kentucky Medical Center, Annex #2, Room 228, Lexington, Kentucky 40506.

SUMMER CAMP FOR HEMOPHILIA BOYS—The Midwest Chapter of the National Hemophilia Foundation will be sponsoring a two-week summer camp for boys from June 16 thru June 30, 1974. Boys between the ages of 6 and 14 with hemophilia may attend for either one or two weeks. A Pediatric Hematologist will be living at camp for the entire time. For information contact William Rushakoff, Executive Director, Midwest Chapter, National Hemophilia Foundation, 327 South LaSalle Street, Room 648, Chicago, 60604.

HOUSE STAFF SYMPOSIUM ON APRIL 4—"House Staff Issues of Today" will be the theme of the symposium sponsored by the ISMS Advisory Committee on Students-in-Training and Merck, Sharp and Dohme on April 4, 1974, 1:30 p.m., at the Conrad Hilton. Moderator for the program is Bruce Fagel, M.D. Featured guest speakers for the day are Eugene Ogrod, II, M.D. Vice Chairman of the AMA Committee on House Staff Affairs and former Intern/Resident Delegate to the AMA; and Michael Stocker, M.D., President, Physicians National House Staff Association.

The Symposium is open to all interested house staff physicians.

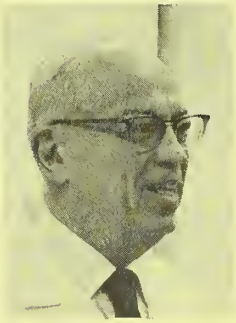
PHYSICIAN IN THE NEWS—**David Presman, M.D.**, Chicago, has been chosen President-Elect of the North Central Section of the American Urological Association; **Dharmapuri Vidyasagar, M.D.**, has been appointed Director of Newborn Nurseries at the University of Illinois Hospital, Chicago.

Illinois physicians recently certified as Diplomates of the American Board of Anesthesiology are: **Suresh K. Agarwal, M.D.**, Hazelcrest; **Pierre Aupont, M.D.**, Chicago; **Bani Bhattarcharyya, M.D.**, Aurora; **Robert S. Forbes, M.D.**, Decatur; **William J. Kramer, M.D.**, Rockford; **Tai Min Lai, M.D.**, Palos Heights; **Murugiah Mani, M.D.**, Chicago; **Dionisio R. Marucut, M.D.**, Elmhurst; **William J. Matthews, III, M.D.**, Chicago; **Cenon M. Menes, M.D.**, Clarendon Hills; **Usharani Nimmagadda, M.D.**, Glenview; **Shyam B. Prasad, M.D.**, Lombard; **Pedro L. Roda, M.D.**, Clarendon Hills; **Gwendolyn B. Schmidt, M.D.**, Chicago; **Daljeet Singh, M.D.**, Forest Park; **Kottarathil Venugopal, M.D.**, Glen Ellyn; and **Martin E. Zadigan, M.D.**, Waukegan.

Lawrence M. Solomon, M.D., Highland Park, has been appointed Associate Dean of the Abraham Lincoln School of Medicine.

Richard Dudley, Jr., M.D., Chicago, a psychiatry resident, has been named as a Intern/Resident representative to the AMA Council on Long Range Planning. Under this Council, Dr. Dudley is Chairman of the No. 1 Mission Group which is in charge of direct service to the public. **Kong Meng Tan, M.D.**, Chicago, radiology resident, has been elected as Chairman of the AMA Committee on House Staff Affairs.

Dr. Noel G. Shaw Retires



St. Francis Hospital of Evanston recently presented a plaque of appreciation to Dr. Noel G. Shaw of Evanston, upon his retirement from the St. Francis Hospital Medical Staff. Dr. Shaw, who joined the Hospital staff in 1932, served as President of the Medical and Dental Staff in 1954, Chairman of the Department of Pediatrics from 1952 to 1957, and Chairman of Pediatric Education in 1970.

Dr. Shaw, who is listed in the 38th Edition of **Who's Who In America**, presented the Distinguished Alumnus Award from Austin College in 1968 and the Distinguished Service Award from the Pediatric Society in 1973.

During his 43-year medical career, Dr. Shaw actively participated in the American Medical Association, holding office as Chairman of the Illinois pediatrics section in 1956 and President of the Chicago chapter in 1965. Dr. Shaw also served as President of the North Suburban Branch of the Chicago Medical Society in 1957, and President of the Chicago Pediatric Society in 1958.

ABBOTT

lacidyl®
(HCHLORVYNOL)

rief Summary

lications—Placidyl (ethchlorvynol) is indicated short-term hypnotic therapy in the management insomnia.

traindications—Drug hypersensitivity and porria.

rnings—Not recommended during the first and ond trimester of pregnancy. Caution patients possible combined exaggerated effects with hol, barbiturates, tranquilizers or other CNS ressants. Exaggerated effects might result in ring of vision, paralysis of accommodation and ound hypnosis. Caution patients concerning ing a motor vehicle, operating machinery, or r hazardous operations requiring alertness aftaking the drug. ADMINISTER WITH CAUTION PATIENTS WITH SUICIDAL TENDENCIES AND NOT PRESCRIBE LARGE QUANTITIES OF THE UG. Adjustment of the dosage of oral anticoagnts might be necessary when beginning ethchlorl therapy, during therapy, or after stopping apy. This drug is not recommended for use in dren. PLACIDYL HAS THE POTENTIAL FOR DEVELOPMENT OF PSYCHOLOGICAL AND SICAL DEPENDENCE. INSTANCES OF SEE WITHDRAWAL SYMPTOMS, INCLUDING NVULSIONS AND DELIRIUM CLINICALLY SIMR TO THOSE SEEN WITH BARBITURATES, E BEEN REPORTED IN PATIENTS TAKING ULAR DOSES AS LOW AS 1000 MG. PER DAY R A PERIOD OF TIME WHEN THE DRUG WAS DENLY DISCONTINUED. PROLONGED ADISTRATION OF THE DRUG IS NOT RECOMDED. Addiction-prone patients or those who likely to increase dosages of the drug on their initiative should be observed for evidence of s or symptoms which may indicate possible y withdrawal or abstinence symptoms. Signs symptoms associated with withdrawal and abence include unusual anxiety, tremor, ataxia, ring of speech, memory loss, perceptual disons, irritability, agitation and delirium. Other well defined signs and symptoms, not necesy due to withdrawal and abstinence, may ine anorexia, nausea or vomiting, weakness, iness, sweating, muscle twitching and weight . Abrupt discontinuance of Placidyl following onged overdosage may result in convulsions delirium.

autions—Toxic amblyopia has been reported long-term continuous use of ethchlorvynol. anent visual defects have been observed, algh amblyopia has improved after discontinuaof the drug. Drug dosage should be limited elderly and debilitated patients to the smallest tive amount. If pain is present, this drug uld only be given if insomnia persists after is controlled with analgesics. Caution is adin prescribing the drug for patients who are g treated with either MAO inhibitors or antiessants. Transient delirium has been reported the combination of Placidyl and amitryptyline. dosage should be reduced if prescribed for nts receiving MAO inhibitors or antidepress. Caution should be exercised in patients impaired hepatic or renal function. Patients respond unpredictably to barbiturates or alcoor who exhibit excitement and release of inhiin in association with such agents, may also t in this way to Placidyl. Rarely, patients may bit symptoms suggestive of an unusual susibility to the drug, such as prolonged hypnosis, ound muscular weakness, excitement, hysteria, yncope without marked hypotension. Transient iness or ataxia may occur.

erse Reactions—Hypotension, nausea or vom, gastric upset, aftertaste, blurring of vision, ness, facial numbness, and allergic reaction ied by urticaria have been reported following idyl administration. Mild "hangover" and symps of mild excitation have occurred in some nts. There have been rare reports of cholestatic dice occurring in patients taking ethchlorvynol. w cases of thrombocytopenia have been red in patients receiving ethchlorvynol. 304431

Give us his nights.

Prescribe Placidyl. Chances are, we'll give him a good night's sleep.

Insomnia may often accompany surgical convalescence. During those long nights following surgery, sleep can be as elusive as it is vital.

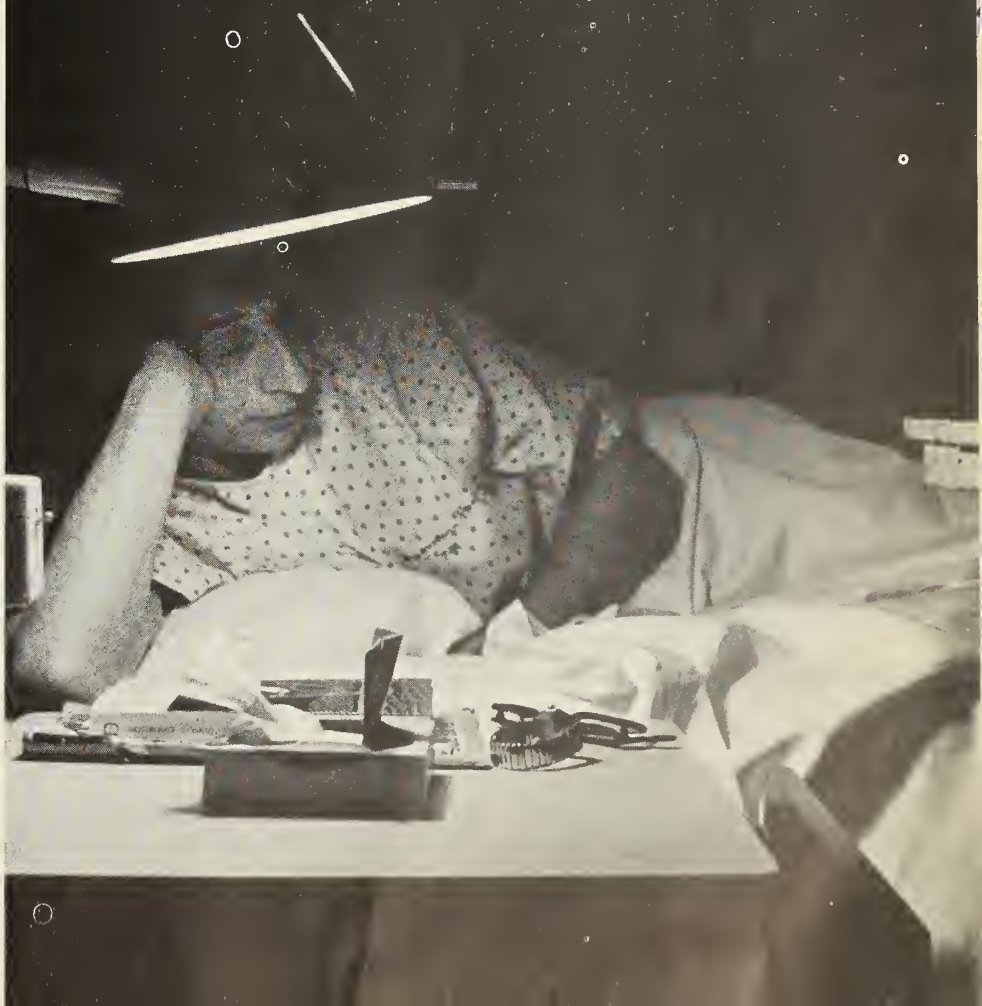
When sleep is synonymous with therapy, remember . . . Placidyl is synonymous with sleep. It has been for over 17 years.

If time is the criterion to inspire your confidence . . . you can rest assured with Placidyl.

Prescribed by physicians for over 17 years.

Placidyl® Ⓒ IV

(ETHCHLORVYNOL CAPSULES, 500 or 750 mg.)



Dr. Lashof Answers Questions For ISMS

MEDICHEK—The Illinois Program of Early Periodic Screening, Diagnosis and Treatment—What Is It?



JOYCE C. LASHOF, M.D., Director
the Illinois Deportment of Public Heal

Dr. Lashof, just what is the Illinois MEDICHEK Program?

It is a program of early periodic screening, diagnosis and treatment (EPSDT) mandated by federal regulation under Title XIX. In Illinois, the Early Periodic Screening, (EPS) part of the program has been named MEDICHEK. It's a combined program effort between the Departments of Public Health and Public Aid for the express purpose of establishing and mobilizing methods of delivering continuous health care to children—ages 0 through 20—who are eligible for medical assistance.

IDPH will develop health screening resources throughout the State which are capable of providing follow-up diagnostic and treatment services or can make the appropriate referrals. MEDICHEK also will offer consultation to service providers through Regional Coordinators.

The Data Processing Division will verify payment for the services rendered which, in turn, will be reimbursed by IDPA.

Who are eligible?

All children, ages 0 through 20, who are eligible for Medicaid, can be enrolled in the MEDICHEK Program. It is estimated that the total target population over the state for Fiscal Year 1975 is approximately 800,000 persons.

What type of services are provided?

A periodic schedule of visits has been established and the procedures to be carried out include: (1) Periodic health appraisals obtained by a history and physical examination with particular emphasis on growth and development; (2) comprehensive immunization program and updating of previous immunizations; (3) periodic screening for urine sugar and protein, hemoglobin or hematocrit and T.B. testing; (4) screening when indicated to detect specific conditions including lead poisoning, sickle cell abnormality and venereal disease; (5) dental examinations at age 3 and above; and (6) vision and hearing screening at intervals beginning at age 3 and provided by the Illinois Department of Public Health Vision and Hearing Program. A specific schedule is available to serve as a guide to the MEDICHEK Program. (See Table 1).

Why are these services being provided?

This target population has not experienced easy access to preventive health services in the past and for economic and other reasons their health services usually have been crisis oriented. To meet the needs of this child population, MEDICHEK was designed to provide health screening services not covered under Medicaid provisions.

MEDICHEK eligibility will be determined by IDPA which also will be responsible for outreach efforts. IDPH will develop the appropriate medical provider facilities, will maintain adequate standards for the delivery of services and verify payments for services. Both departments will cooperatively develop appropriate methods for follow-up of abnormal cases and maintain an adequate administrative structure capable of covering the program demands.

How will the services be provided?

MEDICHEK services will be provided through a prescribed screening schedule by physicians, dentists, and medical care and facilities. Wherever possible, a sufficient number of providers will be enlisted throughout the State so that the recipients can have freedom of choice in obtaining MEDICHEK services.

(Continued on page 282)

Table I
Early and Periodic Screening Program Schedule of Visits and Procedures

Age	Required Procedures	Elective Procedures (May be ordered by Physician if indicated)
6 weeks	Visit (1) DPT (2) OPV (2)	Hemoglobin or Hematocrit (3)
4 months	Visit (1) DPT (2) OPV (2)	Hemoglobin or Hematocrit (3)
6 months	Visit (1) DPT (2) OPV (2)	Hemoglobin or Hematocrit (3) Urinalysis (4) Tuberculin Test (5)
9 months	Visit (1) Hemoglobin or Hematocrit (3) Tuberculin Test (5)	Blood Lead Level (6) Sickle Cell Screening (7)
1 year	Visit (1) Urinalysis (4) Measles/Rubella Immunization (2)	Hemoglobin or Hematocrit (3) Blood Lead Level (6) Sickle Cell Screening (7)
18 months	Visit (1) DPT-Booster (2) OPV-Booster (2)	Hemoglobin or Hematocrit (3) Blood Lead Level (6) Sickle Cell Screening (7)
2 years	Visit (1) Hemoglobin or Hematocrit (3) Urinalysis (4) Tuberculin Test (5)	Blood Lead Level (6) Sickle Cell Screening (7)
3 years	Visit (1) Hemoglobin or Hematocrit (3) Urinalysis (4) Tuberculin Test (5) Dental Visit (8)	Blood Lead Level (6) Sickle Cell Screening (7)
4 years	Visit (1) Hemoglobin or Hematocrit (3) Urinalysis (4) Tuberculin Test (5) Dental Visit (8)	Blood Lead Level (6) Sickle Cell Screening (7)
5 years (entrance school exam)	Visit (1) Hemoglobin or Hematocrit (3) Urinalysis (4) Tuberculin Test (5) DPT-Booster (2) OPV-Booster (2) Dental Visit (8)	Blood Lead Level (6) Sickle Cell Screening (7)
6 years	Visit (1) Hemoglobin or Hematocrit (3) Urinalysis (4) Tuberculin Test (5)	Blood Lead Level (6) Sickle Cell Screening (7) Immunizations not given according to recommended schedule (9)
7 years	Dental Visit (8) Hearing Screening (9)	
8 years	Dental Visit (8)	
9 years	Dental Visit (8)	
10 years (5th grade school exam)	Visit (1) Hemoglobin or Hematocrit (3) Urinalysis (4) Tuberculin Test (5) Dental Visit (8)	Sickle Cell Screening (7) Immunizations not given according to recommended schedule (9)
11 years	Dental Visit (8)	
12 years	Dental Visit (8)	
13 years	Dental Visit (8)	
14 years (9th grade school exam)	Visit (1) Hemoglobin or Hematocrit (3) Urinalysis (4) Tuberculin Test (5) Td Booster (2) Dental Visit (8)	Sickle Cell Screening (7) Immunizations not given according to recommended schedule (9) Standard test for Syphilis (10) In females (11) Culture for gonorrhea Pap Smear
15 years	Dental Visit (8)	
16 years	Dental Visit (8)	
17 years	Visit (1) Hemoglobin or Hematocrit (3) Urinalysis (4) Tuberculin Test (5) Dental Visit (8)	Sickle Cell Screening (7) Immunizations not given according to recommended schedule (9) Standard test for Syphilis (10) In females (11) Culture for gonorrhea Pap Smear
18 years	Dental Visit (8)	
19 years	Dental Visit (8)	
20 years	Visit (1) Hemoglobin or Hematocrit (3) Urinalysis (4) Tuberculin Test (5) Dental Visit (8)	Sickle Cell Screening (7) Immunizations not given according to recommended schedule (9) Standard test for Syphilis (10) In females (11) Culture for gonorrhea Pap Smear

In Gonorrhea

Injection WYCILLIN®

(sterile procaine penicillin G suspension) Wyeth

Penicillin in large doses remains the drug of choice in therapy of gonorrhea. Among penicillins, first choice recommended by the national Center for Disease Control for parenteral therapy of uncomplicated gonorrhea is aqueous procaine penicillin G.

Administration of 4.8 million units together with 1 gram oral probenecid, preferably given at least 30 minutes prior to injection, is recommended in treatment of uncomplicated gonorrhea.

Indications: In treatment of moderately severe intections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage torm. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following intection will usually respond to adequate dosages ot intramuscular procaine penicillin G.—*N. gonorrhoeae:* acute and chronic (without bacteremia).

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent tollowing parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports ot individuals with a history ot penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. It an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories ot signiticant allergies and/or asthma.

Caretully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. It there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. ot a 1 to 2 percent procaine solution. Development ot an erythema, wheal, tlare or eruption indicates procaine sensitivity. Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneticial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. It new intections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

It allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is lite threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, pertorm proper diagnostic procedures, including darktield examinations. In all cases in which concomitant syphilis is suspected, pertorm monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, tever, edema, arthralgia and prostration. Severe and often tatal anaphylaxis has been reported. (See "Warnings.")

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Administer only by *deep intramuscular injection,* in upper outer quadrant ot buttock. In intants and small children, midlateral aspect ot thigh may be preferable. When doses are repeated, vary injection site. Betore injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates ot *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug ot choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal intections (uncomplicated)—Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at ditferent sites at one visit, together with 1 gram ot oral probenecid, preterably given at least 30 minutes prior to injection.

NOTE: Treatment ot severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment tor gonorrhea (male and female) is accomplished with same treatment schedules as tor uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate it positive; otherwise, a culture specimen should be obtained trom the anterior urethra. In the temale, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated it urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists ot 4.8 million units. I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the temale, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae.* Follow-up treatment consists ot 4.8 million units daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test tor syphilis at the time ot diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage ot syphilis.

Composition: Each TUBEX® disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate bufter, and as w/v approximately 0.7% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. polyvinylpyrrolidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Denise has VD.

Let's keep it from getting around.

Actual new cases of infectious syphilis apparently reached the 100,000 mark during the past year; new cases of gonorrhea, more than 2.5 million. That VD is rampant again is due, in large part, to the multiple contacts of teenagers like Denise.

By administering adequate doses of the recommended types of penicillin, you can usually cure VD in the beginning stages. And destroy another link in the chain of infection.

Radiology

WORKSHOP IN DIAGNOSTIC RADIOLOGY
For: Physicians, Residents, & Technologists. 5-day workshop, April 1-5, 1974, Northwestern Univ. Med. Sch., Chicago. **Sponsor, contact:** Div. of Radiological Physics, Northwestern Mem. Hospital—Wesley Pavilion, 250 E. Superior St., Chicago, IL 60611.

DOSIMETRY
For: Physicians, Residents, & Technologists. 5-day workshop, April 15-19, 1974, Northwestern Univ. Med. Sch., Chicago. **Sponsor, contact:** Div. of Radiological Physics, Northwestern Mem. Hospital—Wesley Pavilion, 250 E. Superior St., Chicago, IL 60611.

DIAGNOSTIC RADIOLOGY
For: Family physicians. April 16-20, 1974, Chicago. **Hrs. of Instr.:** 35. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 25. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

RADIOLOGY
For: Radiologists. Symposium, April 24-26, 1974, Marion County Gen. Hosp., Indianapolis. **Hrs. of Instr.:** 21. **CME Credit:** AAFP, AMA Category 1. **Fee:** $115. **Sponsor, contact:** Mr. John Roscoe, Indiana Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, IN 46202.

Surgery

SURGERY OF THE GASTROINTESTINAL TRACT
For: Specialists. April 8-12, 1974, Chicago. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 55. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

ANNUAL MEETING
For: Members & Applicants to American College of Surgeons. April 19-20, 1974, Springfield, Ill. **Sponsor:** Ill. Chap., Amer. Coll. Surgeons. **Contact:** Otto Metzmaker, M.D., 614 E. Carpenter St., Springfield, 62702.

RAPIDLY PROGRESSIVE GLOMERULONEPHRITIS
For: All physicians. Lecture, April 10, 1974, 11 a.m., Martha Washington Hospital, Chicago. **Hrs. of Instr.:** 1. **CME Credit:** AMA Category 1. **Speaker:** Edmund Lewis, M.D., Univ. of Chicago. **Sponsor, contact:** F. Lopez-Fernandez, M.D., Martha Washington Hosp., 4055 N. Western Ave., Chicago, IL 60618.

Urology

UROLOGY TODAY
For: Urologists. Symposium, April 10, 1974, Indianapolis. **Hrs. of Instr.:** 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35. **Sponsor, contact:** Mr. John Roscoe, Indiana Univ. Sch. Med., 1100 W. Michigan St., Indianapolis, IN 46202.

MAY

Anesthesiology

MAC XI—11th MIDWEST ANESTHESIOLOGY CONFERENCE
For: Anesthesiologists. May 16-18, 1974, Conrad Hilton Hotel, Chicago. **Hrs. of Instr.:** 14. **CME Credit:** AMA Category 1. **Fee:** $25. **Sponsor, contact:** Ill. Soc. Anesthesiol., 2750 W. 15th St., Chicago, IL 60608.

Cardiology

ELECTROCARDIOLOGY REVIEW
For: Family Physicians, Internists, Pediatricians. Symposium, May 1-2, 1974, Indianapolis. **Hrs. of Instr.:** 12. **CME Credit:** AAFP, AMA Category 1. **Fee:** $50. **Sponsor, contact:** Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

CARDIOLOGY TODAY—RECENT ADVANCES IN TREATMENT & DIAGNOSIS
For: All physicians. May 6-9, 1974, Iowa City. **Hrs. of Instr.:** 32. **CME Credit:** AMA Category 1. **Fee:** $200. **Sponsor, contact:** Univ. of Iowa Coll. of Med., Newton Rd., Iowa City, Ia. 52242.

INTERMEDIATE ELECTROCARDIOGRAPHY
For: All physicians. May 9-10, 1974, Chicago. **Hrs. of Instr.:** 14. **CME Credit:** AMA Category 1. **Fee:** $75. **Reg. Limit:** 35. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

MILD & MODERATE HYPERTENSION
For: Internists & Osteopaths. Symposium, May 23-24, 1974, Stouffer's Riverfront Inn, St. Louis. **Hrs. of Instr.:** 12. **CME Credit:** AAFP. **Fee:** $30 (physicians); $10 (house-staff & paramed.) **Reg. Deadline:** May 10. **Sponsor, contact:** Washington Univ. Sch. of Med., Ofc. of CME, 660 S. Euclid Ave., St. Louis, 63110.

Dermatology

SPECIALTY REVIEW COURSE IN DERMATOLOGY
For: Specialists. 5-day course, May 6-10, 1974, Chicago. **Hrs. of Instr.:** 35. **CME Credit:** AMA Category 1. **Fee:** $150. **Limit:** 75. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, Ill. 60612.

Emergency Care

18TH ANNUAL POSTGRADUATE COURSE ON FRACTURES & OTHER TRAUMA
For: Orthopaedic Surgeons, General Surgeons, General Physicians. May 8-11, 1974, Sheraton-Chicago Hotel, Chicago. **Hrs. of Instr.:** 28. **CME Credit:** AAFP, AMA Category 1. **Fee:** $140. **Sponsor:** Chicago Comm. on Trauma, Amer. Coll. of Surgeons. **Contact:** Ralph T. Lidge, M.D., c/o Amer. Coll. Surgeons, 55 E. Erie St., Chicago, IL 60611.

EMERGENCY TRAUMA SEMINAR
For: Family Physicians, Internists, Occupational Med. Symposium, May 9, 1974, Home Hospital, Lafayette. **Hrs. of Instr.:** 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35. **Sponsor, contact:** Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

HOSPITAL PROGRAM—MUSCULO-SKELETAL TRAUMA
For: All physicians. Monthly clinical program, May 9, 1974, 8 p.m., Childrens Mem. Hospital, Chicago. **Hrs. of Instr.:** 2. **CME Credit:** AMA Category 1. **Sponsor:** Chicago Comm. on Trauma, Amer. Coll. of Surgeons. **Contact:** Howard W. Schneider, M.D., 238 W. 154th St., Harvey, Ill. 60426.

General Interest

SPRING CLINICAL CONFERENCE
For: All physicians. 3-day conference, May 9-11, 1974, Univ. of Missouri Med. Center, Columbia. **Hrs. of Instr.:** 18. **CME Credit:** AMA Category 1. **Sponsor, contact:** Univ. of Missouri-Columbia Sch. of Med., 807 Stadium Blvd., Columbia, Mo. 65201.

THERAPEUTICS
For: Family Physicians. May 8-9, 1974, Towsley Center for CME, Ann Arbor, Mich. **Hrs. of Instr.:** 14. **CME Credit:** AMA Category 1. **Fee:** $75. **Sponsor, contact:** Univ. of Michigan Med. Cntr., Towsley Cntr. for CME, Ann Arbor, MI 48104.

General Medicine

GENERAL MEDICINE LECTURE SERIES
For: All physicians. Lecture series, May 14, 28, 1974, St. Mary of Nazareth Hospital, Chicago. **Hrs. of Instr.:** 2 each. **CME Credit:** AAFP. **Sponsor, contact:** A. R. Sapienza, M.D., St. Mary of Nazareth Hosp. Cntr., 1120 N. Leavitt St., Chicago, IL 60622.

Internal Medicine

DIABETES
For: All physicians. Seminar, lecture, May 10, 1974, 10 a.m., American Hospital; May 10, 6 p.m., Lincolnwood Hyatt House; May 11, 10 a.m., Bethesda Hospital, Chicago. **Hrs. of Instr.:** 5. **CME Credit:** AAFP, AMA Category 1. **Fee:** $10 (non-staff, for dinner). **Reg. Deadline:** May 6. **Sponsor:** FAB^3-CME. **Contact:** Mr. J. Pardee, American Hosp., 850 W. Irving Pk. Rd., Chicago, Ill. 60613, (312) LA 5-6780.

ADVANCES IN INTERNAL MEDICINE
For: Internists. May 20-23, 1974, Towsley Center for CME, Ann Arbor, Mich. **Hrs. of Instr.:** 28. **CME Credit:** AMA Category 1. **Fee:** $130. **Sponsor, contact:** Univ. of Michigan Med. Cntr., Towsley Cntr. for CME, Ann Arbor, MI 48104.

DIABETES SYMPOSIUM
For: Internists, Family Physicians. Symposium, May 29, 1974, Holiday Inn. Merrillville, Ind. **Hrs. of Instr.:** 6. **CME Credit:** AAFP, AMA Category 1. **Fee:** $35. **Sponsor, contact:** Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Obstetrics/Gynecology

COMMON GENETIC DISEASES
For: All physicians. May 6-10, 1974, Chicago. **Hrs. of Instr.:** 35. **CME Credit:** AMA Category 1. **Fee:** $200 **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

SPECIALTY REVIEW COURSE IN OB/GYN
For: Specialists. May 13-24, 1974, Chicago. **Hrs. of Instr.:** 86. **CME Credit:** AMA Category 1. **Fee:** $300. **Reg. Limit:** 85. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, Ill. 60612.

OB-GYN ROUNDS
May 19-20, 1974, Univ. of Missouri Med. Center. Columbia, Mo. **Hrs. of Instr.:** 12. **CME Credit:** AMA Category 1. **Sponsor, contact:** Univ. of Missouri-Columbia Sch. of Med., 807 Stadium Blvd., Columbia, Mo. 65201.

FETAL & PERINATAL MEDICINE
For: Ob-Gyn, Family Physicians. Symposium, May 21-22, 1974, Indianapolis. **Hrs. of Instr.:** 12. **CME Credit:** AAFP, AMA Category 1. **Fee:** $50. **Sponsor, contact:** Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Ophthalmology

GLAUCOMA CONFERENCE
For: Ophthalmologists. May 1-3, 1974, Towsley Center for CME, Ann Arbor, Mich. **Hrs. of Instr.:** 17. **CME Credit:** AMA Category 1. **Fee:** $110. **Sponsor, contact:** Univ. of Michigan Med. Cntr., Towsley Cntr. for CME, Ann Arbor, MI 48104.

CLINICAL ECHO-OPHTHALMOLOGY COURSE
For: Specialists. May 1-3, 1974, Univ. of Iowa Mem. Union, Iowa City. **CME Credit:** AMA Category 1. **Fee:** $150. **Sponsor, contact:** Univ. of Iowa Coll. of Med., Newton Rd., Iowa City, IA 52242.

Pathology

8th TUTORIAL ON CLINICAL CYTOLOGY
For: Specialists. May 19-23, 1974 (Part I, Gynecologic Cytol.); May 23-25 (Part II, Diagnostic Cytol. Other Anatomic Sites), Univ. of Chicago Center for Cont. Educ., Chicago. **Hrs. of Instr.:** 40 (Part I); 20 (Part II). **CME Credit:** AMA Category 1. **Fee:** $275 (Part I); $175 (Part II); $350 (both). **Reg. Limit:** 160. **Sponsor, contact:** Univ. of Chicago, Cntr. for Cont. Educ., 1307 E. 60th St., Chicago, Ill. 60637.

Pediatrics

PEDIATRIC APPROACH TO THE PREVENTION OF ADULT DISEASES
For: All physicians. Frontiers of Medicine lecture, May 8, 1974, Billings Hospital, Chicago. **Hrs. of Instr.:** 3½. **CME Credit:** AAFP, AMA Category 1. **Fee:** $15. **Sponsor, contact:** Univ. of Chgo. Frontiers of Medicine. Box 451, 950 E. 59th St., Chicago, IL 60637.

9th ANNUAL MULTIDISCIPLINARY CHILD CARE CONFERENCE
For: All physicians. May 8-9, 1974, Stouffers Inn. Indianapolis. **Hrs. of Instr.:** 14. **CME Credit:** AMA Category 1. **Sponsor, contact:** Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

PEDIATRIC HEMATOLOGY
For: Pediatricians. Half-day roundtable, May 22, 1974, Loyola Univ. Medical Center Auditorium, Maywood, Ill. **Hrs. of Instr.:** 4. **Fee:** $10. **Reg. Deadline:** May 20. **Sponsor:** Dept. of Pediatrics, Loyola Univ. Stritch Sch. of Med. **Contact:** Pediatrics Roundtables, c/o E. F. Diamond, M.D., 2160 S. First Ave., Maywood, Ill. 60153.

Psychiatry

RECENT ADVANCES IN NEUROSCIENCES
For: Psychiatrists, neurologists, May 30-31, 1974, Chicago. **Hrs. of Instr.:** 16. **CME Credit:** AMA Category 1. **Fee:** $75. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, Ill. 60612.

Radiology

BONE & JOINT RADIOLOGY
For: Radiologists, Orthopedic Surgeons. Symposium, May 1-3, 1974, Univ. of Kentucky Medical Center & Continental Inn, Lexington, Ky. **Hrs. of Instr.:** 15. **CME Credit:** AMA Category 1. **Fee:** $225. **Reg. Deadline:** April 1. **Sponsor, contact:** Ofc. of Cont. Educ., Coll. of Med., Univ. of Kentucky, Lexington, 40506.

REVIEW CONFERENCE
For: Residents in Radiology. 5-day workshop, May 6-10, 1974, Northwestern Univ. Medical School, Chicago. **Sponsor, contact:** Div. of Radiological Physics, Northwestern Mem. Hosp., Wesley Pavilion, 250 E. Superior St., Chicago, Ill. 60611.

NUCLEAR MEDICINE
For: Specialists. May 13-17, 1974, Iowa Memorial Union, Iowa City. **Hrs. of Instr.:** 35. **CME Credit:** AMA Category 1. **Fee:** $150. **Sponsor, contact:** Univ. of Iowa Coll. of Med., Newton Rd., Iowa City, 52242.

Surgery

ADVANCES IN SURGERY
For: Specialists. May 6-10, 1974, Chicago. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, Ill. 60612.

SURGERY OF TRAUMA
For: All physicians. May 13-16, 1974, Chicago. **Hrs. of Instr.:** 28. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 55. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, 60612.

Urology

ANNUAL MEETING, AMERICAN UROLOGICAL ASSN.
May 19-23, 1974, Chase Park Hotel, St. Louis. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Fee:** $130. **Sponsor, contact:** Amer. Urological Assn., Inc. 1120 N. Charles St., Baltimore, Md. 21201.

surgical grand rounds

Edited By John M. Beal, M.D.

Intussusception in an Adult

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium at Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of February 20, 1973.

Dr. Robert Ward: A 23-year-old male dental student was admitted to Passavant Pavilion on February 8th, complaining of abdominal pain of several hours duration. The pain began rather abruptly, was cramping in nature and was located in the epigastric and periumbilical regions. It was not associated with nausea, vomiting or change in bowel habits. The patient recalled having had several similar but less severe episodes since early childhood, characterized by cramping pain which began suddenly, lasted two to three hours and subsided spontaneously. These had occurred from several times a month to once a year. Past medical history, family history, and review of systems were unremarkable. Physical examination at the time of admission showed a restless, well developed male in mild distress. Blood pressure was 140/80, pulse 88 and temperature 97.8° rectally. Pertinent physical findings were limited to the abdomen which was scaphoid and without surgical scars or distension. Mild tenderness was present in the epigastrium and right lower quadrant. Masses or organomegly were not felt. Bowel sounds were present and hypoactive. Rectal examination was unremarkable. Admission white blood count was 14,400 with a normal differential, hematocrit was 45%. Urinalysis and serum amylase were normal. The chest and abdominal

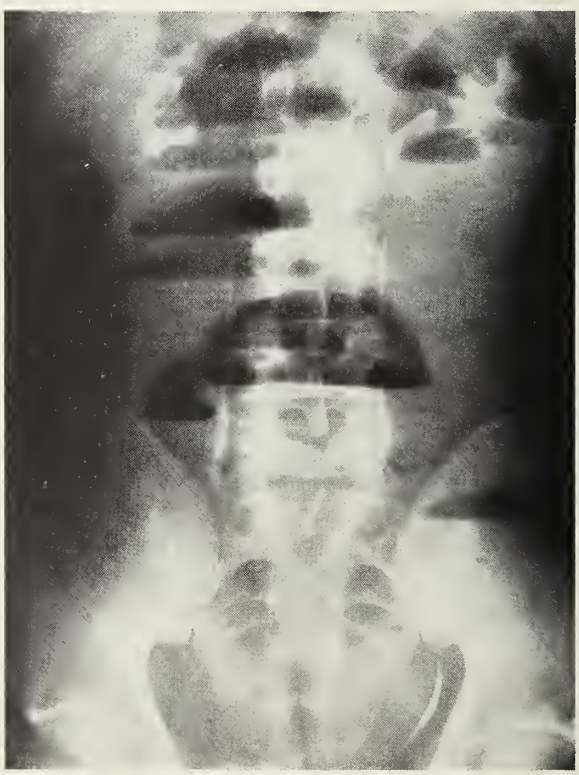


Figure 1. Air fluid levels are demonstrated which are compatible with small bowel obstruction.



Figure 2. Barium enema shows a filling defect in the cecum with widening of the terminal ileum.

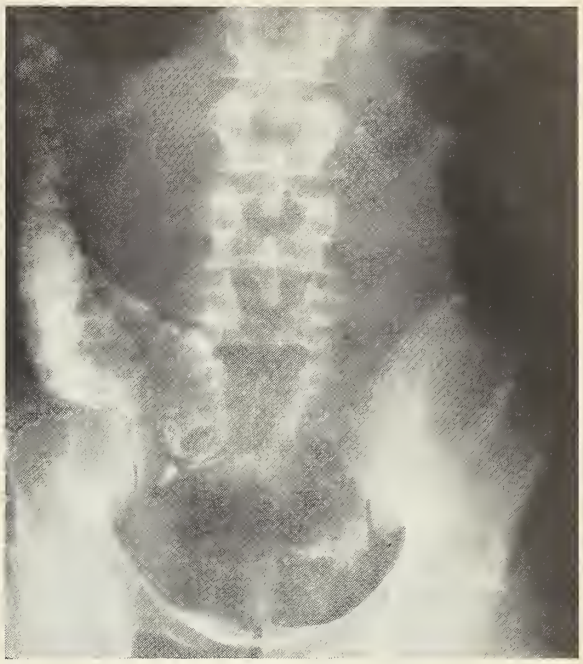


Figure 3. Partially filled colon demonstrates defect compatible with intussusception.

X-rays taken in the emergency room before admission were normal.

The patient was admitted for observation. The following morning he was afebrile without abdominal pain and clinically improved. White count was 8,600. However, 12 hours after admission, he again began to have mild generalized cramping abdominal pain which became steady during the night. The following morning he had mild generalized tenderness with slight distension and absent bowel sounds. Additional X-rays were obtained.

Dr. Earl Nudelman: The urogram films show a small amount of gas in the colon and there are differential air fluid levels in the small bowel; the radiographs are compatible with a mechanical small bowel obstruction. (Figure 1) The barium enema done on the same day shows a filling defect in the cecum and irregular widening of the terminal ileum. This is shown on both the spot radiographs and survey films. The findings are compatible with a diagnosis of intussusception. (Figures 2 and 3) The bowel is dilated and there is an associated filling defect; this could be partially reduced by running the barium into the cecum and displacing the barium into the small intestine. The filling defect, in part, is probably due to some edema of the ileocecal valve. No definate lesion of the cecum or distal small bowel is identified. The appendix is filled and there is considerable reflux of barium into the distal small bowel.

Dr. Robert Ward: Operation was performed on the same day. A lower transverse abdominal incision was made and an intussusception involving the terminal ileum was found. The intussusception was reduced manually without difficulty. The terminal ileum was edematous but there was no other evidence of pathologic change. The small bowel was carefully palpated and was free of defects. The patient had an unremarkable post operative course and left the hospital on the seventh post operative day.

Dr. Joseph Sherman: This differs from intussusception in childhood which I will review briefly. I'm sure you are familiar with the classical history of the eight or nine-month-old child who awakens from a nap crying, flexing his kness onto his abdomen, rolling around in obvious severe pain. The pain lasts a few minutes and is occasionally accompanied by vomiting which is initially nonbilious. The pain subsides, the child is quite pale, sweaty and then a half hour to an hour later pain recurs. Between the attacks, the child plays normally and even may want something to eat. Initially, the abdomen is quite scaphoid and soft. As the episodes of pain continue, the child then starts passing the classical currant

jelly stool. Interestingly, this disease usually occurs in well nourished male children, and seldom in malnourished children. There are two clinical presentations of intussusception which differ from the typical picture. For one, the child can present with severe lethargy. Occasionally, a child with intussusception will present with marked lethargy and will be admitted on the neurology service. They can also present, although this is rare, with thrombocytopenia and purpura because of trapping of platelets within the mass.

This is an interesting disease and is rather uncommon in major pediatric institutions in the United States. About 7 to 10 cases are seen each year in a hospital like Children's Memorial Hospital. In a comparable hospital in Canada or Europe, they see 50 or 60 a year. In children, 95% or so are idiopathic. In the 5% where there is a cause, it's usually a Meckel's diverticulum, ectopic pancreas or a polyp. These children are usually relaxed after the episode of pain and you can feel a sausage shape mass upon examination of the abdomen.

The treatment depends upon when you first see the child. If we see them with a history of less than 24 hours duration, we try barium enema reduction. That means redehydrating the child first, inserting a nasogastric tube and then doing the barium enema. We place the enema tip in and tape the buttocks together and start the barium enema under fluoroscopic control, preferably with the surgeon present. Barium enema reduction is not considered successful until one sees the barium reflux into the terminal ileum. If one can't reduce the mass in 15 or 20 minutes, then one must do a laparotomy. Obviously, if the child has peritonitis or perforation, or a history of pain over 24 hours, we do not perform the barium enema. The recurrence rate, by the way, is about 10%, whether one uses barium enema reduction or operative reduction. In Europe and Canada they claim to reduce about 50-60% of the masses with barium enema; in this country, we are successful about 25% of the time. The best operative approach is through a right lower quadrium transverse muscle splitting incision. In most cases the mass is largely reduced by this approach. Obviously, if the child has necrosis in the mass one must resect the necrotic bowel.

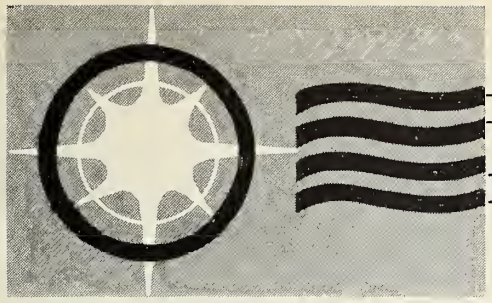
Dr. James Hines: Do you take the appendix out when you're doing this?

Dr. Joseph Sherman: I don't. No. There's usually so much edema, so that it is wiser to leave the appendix.

Dr. Stuart Poticha: Although this presentation is entitled intussusception in an adult, I felt it wise to have Dr. Sherman speak first since 95% of intussusceptions occur in children and 95% of these occur in children below two years of age. The 5% of cases which occur in adults reveal marked differences in the etiology, pathology, symptomatology and treatment. In the first place, the onset of this disease in adults is usually insidious and frequently the disease is chronic and relapsing. This patient's history is quite characteristic of intussusception in an adult, which is a long history of vague abdominal complaints, somewhat suggestive of partial intermittent bowel obstruction relieved spontaneously only to recur. Secondly, the classic finding of currant jelly stools, which commonly occur in children, is usually absent in adults. In 34 patients reported from the New York Hospital, only one patient had passed a currant jelly stool. The most significant difference between intussusception in children and adults is that whereas 95% of the children have no obvious cause for the intussusception, in other words idiopathic or primary intussusception, in the adults the reverse is true.

In a review of the literature, in 1956, 750 cases of intussusception in adults were collected. Approximately 31% of these intussusceptions were due to benign tumors; about 25% were due to malignant tumors; 20% were primary or non specific or idiopathic type that occurs in children; 6% were due to Meckel's diverticula, and the rest were due to various less common causes. Because tumors are associated with intussusception in adults in more than 50% of the cases, the treatment is different in adults. Reduction with a barium enema should never be attempted in adults because 4 out of 5 have a pathologic entity that should be taken care of at operation. The surgical treatment depends upon the location of intussusception. About 1/3 are enteroenteric and efforts should be made to reduce the intussusception and then to take care of the cause. A Meckel's diverticulum or polyp should be excised, while a larger tumor might require a small bowel resection. If the intussusception cannot be reduced, then a resection of the entire intussuscepted mass should be performed. If the intussusception is reduced and there is no obvious cause for it, in other words primary intussusception, no further treatment is indicated.

In these cases, as in children, the recurrence rate is practically zero. If, on the other hand, the intussusception involves the colon, in other words an ileocecal or colocolic intussusception, then the proper treatment is resection of the entire mass without reduction, because most of these cases are caused by malignant tumors. ◄



membership forum

Dear Editor:

It is fashionable these days to write about a real or imagined crisis in American medicine. The most serious crisis of all is yet to come. Professional medical educators, men who either gave up practice or who never were interested in patient care, have led us to the brink of disaster in two ways. First of all, during the past 20 years, not only has the rotating internship been abandoned, but now students are going straight from school into specialty residencies. The deans assured us that the senior year of medical school would take the place of an internship. Just the opposite has happened. In many schools, the entire senior year has been made elective. Students are now almost forced to decide upon a specialty during their junior year. They then take clerkships in their field of interest and start right out into a residency. We no longer are educating doctors; we are producing specialists who have never been exposed to other areas of medicine. On the wards of our hospitals today we have surgical residents who haven't the faintest idea of how to feed a baby, or to treat heart failure or diabetes. Internists and pediatricians are being foisted upon the public who have never seen a perforated ulcer or ruptured appendix. They don't have the simplest of surgical skills.

All of this has been accomplished against the desires of the students, who themselves would welcome an opportunity to take a rotating internship. Most of them have enough common sense to realize that they should have a good background in general medicine. They realize that a future psychiatrist can learn how to calm an unhappy mother and a frightened child in the emergency room while he is sewing up a laceration. The chap who is going into surgery would at least like to know enough neurology so that he can recognize when his patient has had a stroke in the postoperative period. The pressures to ban the rotating internship began when the chairmen of the various departments told students that they would have a better opportunity to get a specific residency if they took a straight internship. The policy spread from one hospital to another and now it is almost impossible for the student who wants a broad general background to obtain a rotating internship. It is almost beyond imagination that this elimination of the rotating internship took place during a time when everyone clearly recognized that we have a super abundance of specialists and too few family practitioners.

We can also blame the deans and other professional medical educators for some of the problems we have had with inner city medical care. At one time the great city-county hospitals provided excellent care to the poor. Beginning in the early 1950's advisors began telling students that they must not intern in the setting of a charity hospital because there would be no teaching. Students were urged to go to either university hospitals where they would get "teaching" or to the large private hospitals where hands were needed to take care of private patients. In all of the years that I tried to recruit interns for the Cook County Hospital in Chicago, there weren't more than a half dozen students who told me that their advisors had even suggested to them that they should look at internships at a county hospital. Certainly, the lack of agressive, English speaking interns and house staff in the large charity hospitals contributed to their downfall in the 1960's. Fortunately, some of them are making a comeback because the medical schools are finally realizing that they need the patients in these institutions for their student's education.

I would beseech every practicing doctor who agrees with me to write to the dean of his medical school and to the Committee on Graduate Education of the American Medical Association to reverse the elimination of the rotating internship and the trend to make the senior year of medical school just another year of specialty training.

John G. Raffensperger, M.D.

* * *

Dear Editor:

A few years ago, a feeble aged pediatrician, with little business, when asked why he didn't retire, responded pitifully, "I have no money!" Others, on the other hand, literally killing themselves on an 80 hour/week work schedule, can ill-afford not to retire. Federal and state income

taxes eat up much of these busy doctors' hard earned income! The late Senator Dirksen, Wilbur Mills, and other have been appealed to by some, who had an unselfish interest in the wider distribution of good medical care.

Some maintained that doctors should be motivated to engage more in the practice of medicine, for which they are especially prepared, rather than diverting one or more hours daily to the study and dealing in the stock market, acquiring cattle feed-lots, or dallying in real estate in order to realize, by long-term capital gain, a more favorable tax position; this being the solution for many to put something aside for their old age.

Certainly our Congressmen, who find so much time engaging in TV histrionics and paid public appearances, could help their constituents back home by not antagonizing their physicians with such annoyances and time consuming strictures as Professional Standards Review (PSRO), a real monkey on their doctors' and hospitals' collective backs!

Wouldn't it seem that these Congressmen and the Administration might more profitably be addressing themselves to encouraging rural and ghetto youths to go into medical schools contracting to return to needy areas to practice?

So, too, our laborers, in the Washington vineyards, might effectively discourage physicians' early retirement by eliminating such distractions from rendering primary care as the filling out of interminable forms required in the socialized medicine of today and in the future.

Could not our legislators ensure better medical care by studying the people who provide it, their needs, and aspirations. They might discover the desirability of promulgating a tax-loop-hole, or even a subsidy, or, even further, a depreciation allowance on the doctors' coronaries! Physical and fiscal security might encourage physicians to restrict their waking hours to the private practice of medicine.

Who will take the message to Washington?

CDO

(Name withheld at request)

LOW-COST GROUP INSURANCE
ANOTHER ISMS MEMBERSHIP PRIVILEGE

THE GROUP DISABILITY PLAN ● Provides up to $300.00 weekly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

BUSINESS OVERHEAD EXPENSE PLAN ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

THE FAMILY MAJOR MEDICAL EXPENSE PLAN ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Gross Daily Hospital Room and Board available. ● Subject to choice of deductible and 80% coinsurance.

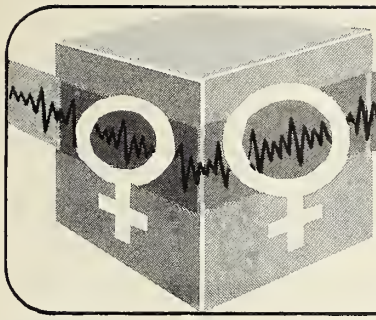
FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

Central Illinois Service Office: 849 Forest Lane—Petersburg, Ill. 62675 • phone 217-632-7220
Wayne J. Hubbert, District Manager



pulse... of the doctor's wife

Mrs. Rosanne K. Frank, *Editor*

From the President's Desk

"On a clear day, rise and look around you," and you will see just on the horizon a group of stars, clustered together, our constellation, Illinois, which we have been searching for and striving toward during the Auxiliary year, 1973-74. By the time of our annual convention, we will have reached that group of stars, and will share with each other the attainments, the accomplishments, the knowledge, and the fun and fellowship of this year of aspirations.

What can the discovery of the luminaries in "Illinois" contribute to the Woman's Auxiliary now and in the future? Principally it means "unity" within the county groups and visionary coordination within the state Board. It foretells the meshing of minds toward contributions enabling us to work to advance health education and the improvement of the quality of life for everyone.

Physicians' wives throughout the state—the young, the elderly, the new, the experienced, the American, the foreign-born, the timid, the gregarious—all with untapped resources and talents, will come together and endeavor harmoniously for the Auxiliary.

Congratulations! Each and everyone of you is a star in the galaxy. May your light shine on and on. It has been a unique privilege for me to serve you as your pilot.

Mrs. Robert (Bea) Hartman
WA/ISMS President

An Invitation

The Woman's Auxiliary of the Illinois State Medical Society and the Chicago Medical Society extend a warm invitation to all auxiliary members, guests and doctors' wives who are non-members to attend the 46th WA/ISMS Annual Meeting, April 3-5 Conrad Hilton Hotel, Chicago.

Your convention committee has put together a delightful three days. We will "Adventure with the Stars" gathering information: learning at general sessions; and having fun at the outstanding social functions.

Please come and enjoy Convention '74 with us. We look forward to seeing all of you.

Mrs. Maynard (Lenore) Shapiro
Convention Chairman

Nomination Committee's Slate of Officers For 1974-75

PRESIDENT	**Mrs. Thomas Glatter**
PRESIDENT-ELECT	**Mrs. Eugene L. Vickery**
VICE-PRESIDENT PROGRAM	**Mrs. Earl Klaren**
VICE-PRESIDENT COMMUNITY SERVICE	**Mrs. Edward Szewczyk**
VICE-PRESIDENT MEMBERSHIP	**Mrs. Ralph Davis**
TREASURER	**Mrs. William Hodges**
RECORDING SECRETARY	**Mrs. Leo Kempton**
DIRECTORS	**1. Mrs. Robert Hartman** **2. Mrs. Paul P. David** **3. Mrs. Harlan Failor**

"Adventure With The Stars"

46th Annual Meeting
Woman's Auxiliary to the Illinois State Medical Society
April 3-6, 1974 Conrad Hilton, Hotel, Chicago

Wednesday, April 3

9:30-10:15 a.m. HOSPITALITY

10:15-11:30 a.m. PRE-CONVENTION BOARD MEETING

LUNCH: Open

1:00 p.m. FIRST DELEGATE SESSION
Upper Summit

HIGHLIGHTS

Presentation & voting on Amendments to Bylaws . . . Report and voting on Nominating Committee

Keynote Speaker
- **DR. ROY PFAUTCH**

3:30 p.m. WA/ISMS PRESIDENT'S ANNUAL REPORT TO ISMS HOUSE OF DELEGATES

5:00-6:00 p.m. SHERRY PARTY
Hospitality Suite

7:30 p.m. BOARD DINNER

REGISTRATION
Lower Level

Wed., April 3	9:00 a.m.-4:00 p.m.
Thurs., April 4	8:00 a.m.-4:00 p.m.
Fri., April 5	8:00 a.m.-4:00 p.m.

Thursday, April 4

8:00-9:00 a.m. HOSPITALITY
Lower Summit

9:00-12:00 a.m. SECOND DELEGATES SESSION
Upper Summit
HIGHLIGHTS
"ALICE IN DANGERLAND"
presented by
Rock Island County Auxiliary
Speakers
- **MR. WALTER LIVINGSTON**
- **MRS. WILLARD C. SCRIVNER**
- **JAMES RYAN, M.D.**

12:15 p.m. RECEPTION AND TICKET BAR
Boulevard Room

12:45-2:00 p.m. PRESIDENTS' LUNCHEON
Honoring Mrs. Scrivner, Mrs. Hartman, Past Presidents and County Presidents

2:00 p.m. FASHION SHOW
presented by *LORD & TAYLOR*

3:30 p.m. THIRD DELEGATE SESSION
Upper Summit
HIGHLIGHTS
Elections-Adopting Budget-Reference Committee Reports
Speaker
- **BERTRAM MOSS, M.D.**

6:00 p.m. ISMS PRESIDENT'S RECEPTION
compliments of *INTRAV*

7:00 p.m. PRESIDENT'S NIGHT
Honoring Dr. and Mrs. Willard C. Scrivner

Friday, April 5

8:00-10:00 a.m. COMPLIMENTARY PUBLIC AFFAIRS BREAKFAST
Boulevard Room

10:00-11:45 a.m. FOURTH DELEGATE SESSION
Upper Summit

HIGHLIGHTS
"ORBITING AROUND THE COUNTIES"

12:00 noon TICKET BAR
Boulevard Room

12:30-1:30 p.m. LUNCHEON
"Friendship is the Salt of the Earth"
Installation of Mrs. Thomas Glatter,
Acting President-Elect

Speaker
- **MRS. JOSEPH KERWIN**

3:00-4:00 p.m. LEADERSHIP WORKSHOP

State and county chairman

CONVENTION ADJOURNMENT

4:30-5:30 p.m. POST-CONVENTION BOARD MEETING

VISIT AMA-ERF
BOUTIQUE
Lower Level

IT IS IMPORTANT TO MAKE YOUR LUNCHEON RESERVATIONS NOW!

All Reservations Payable in Advance to WA/ISMS

Thursday, April 4, 1974, Luncheon and Fashions by Lord and Taylor
Please reserve _____ at $10 per person

Friday, April 5, 1974, Luncheon—Speaker: Mrs. Joseph Kerwin, wife of Capt. Joseph Kerwin, physician/astronaut

Please reserve _____ at $8 per person

NAME _____

ADDRESS _____

All Reservations Must be Accompanied by Check and Received No Later Than March 15, 1974
Mail All Reservations to:

Mrs. Maynard I. Shapiro
505 North Lake Shore Drive
Apt. 5707
Chicago, Illinois 60611

President's Page

(Continued from page 171)

Unfortunately, our role as guardians of the public health is being jeopardized by galloping federalism and interference from other third-parties.

Hospitals, clutching to a questionable interpretation of the Darling Case—which held a private hospital liable for medical staff negligence—are attempting to place physicians in a subservient position to hospital boards.

Insurance carriers have been inclined to establish—without consulting physicians—what they term "usual and customary fee profiles."

And, of course, we are threatened from all sides by the spectre of Potomac planners who ignored the voice of medicine when designating PSRO areas, and although they were unsuccessful, proposed a pre-hospital-admission certification program for Medicare and Medicaid patients. The implications of these proposals require no explanation.

Another tentacle stretching from Washington, the FDA, is strangling development of medications which undoubtedly would prove useful in treating our patients.

We must not abdicate control of our profession to enthusiastic but misguided reformers. We must stand united against further encroachment upon the responsibilities of our profession . . . not only as physicians, but also as public defenders of American health.

William e. Screws M.D.

New Pharmaceutical Specialties

(Continued from page 190)

Dosage: One capsule three or four times daily.
Supplied: Capsules

ZORANE Oral Contraceptive ℞

Manufacturer: Lederle Laboratories

Composition: Norethindrone Acetate	Ethinyl Estradiol	
1 mg.	20 mcg.	Pink
1.5 mg.	30 mcg.	Blue
1 mg.	50 mcg.	Green

Indications: Contraception
Contraindications and Precautions: Those common with contraceptive drugs
Dosage: Daily administration of 21 colored tablets followed by white inert tablet 7 days.
Supplied: Tablets ◄



Is Yours for the asking

No Collateral!
No Endorsers!
No References!

This is a completely confidential source of unsecured credit for professional people wishing to borrow at least $2,000.00 for 12 to 36 months. No endorsers are needed! No references are checked! No information other than the original application is ever required! And, all transactions are conducted in complete privacy by unmarked mail.

To borrow up to $7,500.00 in absolute confidence, you must have annual income of at least $20,000.00 and be between 30 and 65 years of age. If you qualify—call C. W. Conner, Professional Loan Director, at this Toll Free number for a loan application: 800/238-7545 (Tennessee residents call collect 901/523-1461).

Your application can be processed and a check mailed in only two weeks. It's yours for the asking. Larger amounts are available upon request.

Murdock
Acceptance Corporation
P. O. Box 158 • Memphis, Tenn. 38101
Phone 901/523-1461

DOCTORS—
CLINICS—
LABORATORIES

PATIENT BILLING PROBLEMS?
INSURANCE FORM HEADACHES?

WE CAN HELP YOU!!!
(at a surprisingly low cost)

For further information — contact:

FRAN MARK
INDECON, INC.
Suite 525,
300 S. Wacker Drive
Chicago, Illinois 60606
Phone: (312) 786-0220

MEDICHEK

(Continued from page 269)

How will MEDICHEK data and fee payment system be maintained?

A data processing system has been developed for health care information management and fee payment. The Department of Public Health Data Processing portion of the MEDICHEK Program will consist of three major areas: (1) receive incoming MEDICHEK forms, (2) an update of the recipient's health screening data base, and (3) the bill payment cycle. Payment for screening services will be **immediately initiated** upon receipt of a MEDICHEK form completed and submitted by the provider. The MEDICHEK payment system should facilitate early reimbursement to providers. Payment for diagnostic and treatment services will be reimbursed through the existing IDPA payment mechanism.

The health care information derived from the MEDICHEK data base will be compiled for reporting to HEW, and other health agencies. The recipients' health record will be used to maintain an adequate outreach program, and to monitor necessary follow-up diagnostic and treatment services for those with abnormal screening results.

How can physicians obtain further information about the MEDICHEK Program?

To answer any questions relative to participation in the MEDICHEK Program, please call (217) 525-2736 or write Mr. Wesley J. Duiker, Chief, MEDICHEK Program, Illinois Department of Public Health, 535 West Jefferson, Springfield, IL. 62761. ◄

EKG of the Month

(Continued from page 186)

Answers: 1. E 2. A,C

The continuous ECG rhythm strip shows a junctional tachycardia at a rate of 80 beats/minute. The temporary demand pacemaker is not suppressing completely and is thus in competition with the junctional tachycardia. The pacemaker artifact can be seen distorting the ST segment of the junctional beat and gradually moving toward the apex of the T wave. At the apex of the T wave the pacemaker fires the ventricles in line 1, but this beat is followed by two more premature ventricular beats in lines 2 and 3. The apex of the T wave is the area of the vulnerable period. This is the time of the relative refractory period of the heart where single stimuli can produce more than one response. These responses can be called pacemaker induced ventricular tachycardia or repetitive ventricular rhythm. These repetitive ventricular beats have the same significance as the more deleterious ventricular fibrillation.

Therefore, the pacemaker should be turned off and replaced by properly functioning demand system. Following the ventricular tachycardia, the pacemaker is reset and several pacemaker captures occur before the junctional tachycardia takes over again. This suggests that the junctional tachycardia was somewhat depressed by the more rapid ventricular tachycardia. Lidocaine would not be needed here because turning off the pacemaker should cause the ventricular tachycardia to disappear. The junctional tachycardia may be the result of digoxin excess so it should be held. ◄

- **Are you bombarded with propaganda from *Readers Digest*, the beauty parlor, etc.? Learn the answers in the instruction course, "Gynecological problems for the Non-Gynecologist," Thursday, April 4 at the Midwest Clinical Conference, Conrad Hilton Hotel, Chicago.**

- **Am I aggressive enough in managing my hypertensive patients? Get the latest in the instruction course, "Hypertension," Friday, April 5, at the Midwest Clinical Conference, Conrad Hilton Hotel, Chicago.**

- **Which way should you run when the Code "99" alarm sounds? Learn the latest in the "Management of Cardiovascular Emergencies" course, Wednesday, April 3, at the Midwest Clinical Conference, Conrad Hilton Hotel, Chicago.**

NEW BADEN: Physician wanted to take over established practice in town of 2,000 population. New medical building with equipment; financial aid available. Two large metropolitan hospitals within 15 minute drive; St. Louis within 40 minute drive. Retiring physician available to assist in transition of practice. Contact: Walt Spihlman, R.Ph., 201 E. Hanover, New Baden, 62265, 618-588-3517. (4)

PONTIAC: Population 11,000, Trade Area 50,000. 100 miles south of Chicago on Route 55-66. Family Practitioners, Orthopedists and Urologists. Office space available adjacent to Hospital. Contact: Sister Elizabeth, St. James Hospital, 610 East Water Street, Pontiac, 61764 or call collect: 815-844-5134. (4)

PRINCETON: Population 7,800; County population 38,000. Excellent living conditions; good family community—no problems. Modern 180-bed hospital. Unlimited income for Family Physicians and Pediatricians. 2 hours to Chicago; 1 hour to Peoria & Quad Cities on I-80. Call collect: John Revell, 606 South Main Street, Princeton, 815-872-1255 or 815-875-3292. (4)

QUINCY: 50,000 population. 325-bed, modern hospital. Need Emergency Room Physicians and an Anesthesiologist. 90 physicians on staff. All major specialties. Two hours northwest of St. Louis. Good recreational facilities, schools. Contact: Larry Swearingen, Blessing Hospital, 1005 Broadway, Quincy, 62301, 217-223-5811. (4)

ROCHELLE: Population 10,000. General Practitioners, Internist-Cardiologist. Group or solo practice. Located 75 miles West of Chicago, near new medical school and university. $2,000,000 addition, 1971. Ultra-modern, 70-bed hospital; new offices adjacent. Excellent schools, recreation. Visit at our expense. Contact: Robert Knapp, Rochelle Community Hospital, Rochelle 61068, 815-562-2181. (8)

ROCKFORD: Population 145,000. Opening in medical center for family physician. Five physicians at present with recent vacancy. Complete office facilities including laboratory and X-ray, one block from 400-bed Rockford Memorial Hospital. Contact: Pieratt Johnson, M.D., 2623 Edgemont Street, Rockford, 815-965-8745. (4)

SALEM: General Practice, Family Practice or Internal Medicine. Population 6,400. County seat serving a population of 20,000. Located 70 miles east of St. Louis on Interstate 57. Accredited hospital with $1,500,000 expansion recently completed. Financial assistance available for solo or group practice. Contact: Dr. Louis Jorel, East Main St., Salem, 62881, 618-548-4323. (4)

SAVANNA: Pediatrician, Internist, or General Practitioner. Illinois community of 5,000 population on Mississippi River. 40-bed open staff hospital; exceptional recreational facilities; excellent schools and churches of all denominations. Option to practice alone or in partnership. Contact: William J. Dayton, 202 Meadowview Knoll, Savanna, 61074, 815-273-2755. (4)

SHELBYVILLE: Population 6,000—drawing population 22,000. New eight man medical ctr. recently opened and attached to 100 bed hospital. Object to secure a medical practice group. Central location within commuting distance of Springfield—60 miles, Decatur 35 miles & St. Louis 115 miles. Located on large lake recreational area. Contact: John Snyder, Shelby County Memorial Hospital, 1st & Cedar Sts., Shelbyville, 62565, 217-774-3961. (4)

SOUTHERN ILLINOIS: Southernmost Illinois Health Care Planning Council—Represents 76,000 population in southern Illinois, with 4 hospitals in the area. Picturesque southern Illinois is proud of its recreational factilities, schools and Southern Illinois University, within commuting distance. Office space and housing available. Contact: Ray Oxford, Planning Director, 421 N. Blanche Street, Mounds, 62964, 618-745-6528. (6)

STAUNTON: Excellent practice available with unlimited opportunities. Let us help you locate in residential town of 4,500 within 40 minutes of St. Louis. New 60-bed hospital under construction. Contact: G. L. Schneider, Administrator, Community Memorial Hospital, 216 W. Pennsylvania, Staunton, 62088, 618-635-2552. (4)

STREATOR: Internist & Family Physician needed to join 11 man (4 Internists & 2 Family Physicians) multispecialty group in community of 20,000 with new clinic building across from hospital, excellent practicing facilities for energetic physician, full insurance benefits, guaranteed income; teaching opportunities. Contact: E. E. Howell, M.D., Streator Medical Clinic, S. C., 104 Sixth St., Streator, 61364, 815-672-0511. (4)

TAYLORVILLE: Clinic opened 1971, needs 2 G.P.'s, with interest in O.B. Presently 1 G.P., 1 Int. Med., 1 Ped., 1 Gen. Surg. and 1 Thor. & Card. Surg. Clinic located adjacent to modern 171 bed hospital with resident pathologist and radiologist. Located 26 miles S.E. SIU Medical School, Springfield. Professional corporation, outstanding benefits, shareholder, 1 year. Contact: Dennis E. Neal, C.P.A., P.O. Box 322, Taylorville, 62568, 217-824-8191. (6)

VANDALIA: Family Practitioner/Surgeon needed. Community of 6,000 with a new hospital and adjoining nursing home. Progressive community; Good schools, 1 hour from St. Louis on Interstate. Office space available close to hospital. Contact: D. H. Rames, M.D., or Larry Harrison, Hospital Administrator, 1029 N. 8th St., Vandalia, 62471, 618-283-3012. (4)

WATSEKA: Population 6,000. Opening in Medical Clinic. 4 physicians at present. 30 Miles from Kankakee. Complete office facilities. Opening for General Practitioner, Internal Medicine or OB/Gyn. Contact Francis Carter, 845 S. 4th Street, Watseka, 60970, 815-432-2461. (4)

WHEATON: Pediatrician(s) to join unique medical office condominum. College town 25 miles west of Chicago. Practice arrangements flexible. Rapid practice expansion assured for right individual(s). Contact: Douglas B. Mains, M.D., Mona Kea Professional Park, 393 Schmale Road, Wheaton, 312-665-9777. (7)

WHITE HALL: Population 3,000. Location midway between St. Louis, Mo. and Springfield, Ill. One physician at present. 30-bed hospital, new nursing home, 80 bed, construction underway increasing to 160 beds. Office facility available. Recreational facilities nearby. Contact: George Stahl, 407 N. Main St. White Hall, 62092, 217-374-2121. (4)

WITT: A modern building designed for two physicians in a rich agricultural community. Hospital nearby. Assistance available for qualifying physicians for immediate occupancy. (Have truck, will move) Contact: Louis Schwartz, 604 E. Allen, Witt, 62094, 217-594-2431. (4)

Obituaries

***Blonder, Edwin J.,** Skokie, died January 23, at the age of 73. He was a retired eye, ear, nose and throat specialist and had practiced 45 years. He graduated from Rush Medical College in 1925.

***Bornstein, Johann S.,** Chicago, died January 19, at the age of 63. He was the Director of Thoracic Medicine at Michael Reese Hospital and a senior attending staff physician at that hospital. Dr. Bornstein was also Past President of the former Tuberculosis Society. He graduated from Rush Medical College in 1937.

***Cannon, Vern Edward,** Decatur, died January 19, at the age of 53.

***Choisser, John Elder,** Harrisburg, died January 22, at the age of 60.

***Dietrich, Edwin F.,** Danville, died January 24, at the age of 67. He graduated from the University of Illinois School of Medicine in 1932.

***Hick, Ford Kimmel,** Oak Park, died December 29, 1973, at the age of 66. He was the Chief of Staff at the Veterans Administration West Side Hospital and a member of the faculty of the University of Illinois College of Medicine where he graduated in 1931.

***Johnson, Titus, M.,** Chicago, died January 15, at the age of 76. He was a medical missionary to Africa and a member of Swedish Covenant Hospital's medical staff since 1936. He graduated from the University of Illinois in 1935.

***Koziol, Stanizlaus M.,** Lincolnwood, died December 26, 1973, at the age of 60. He was a general practitioner specializing in heart ailments and was on the staff of St. Elizabeth's Hospital. He graduated from Loyola Stritch School of Medicine in 1941.

****Peterson, Martin,** Paxton, died December 24, 1973, at the age of 93. He graduated from the University of Illinois in 1906 and practiced medicine for more than 50 years.

***Schwartz, Lester,** Wilmette, died January 1, at the age of 45. He taught anesthesiology at Loyola Stritch School of Medicine and the University of Illinois College of Medicine. He graduated from the Chicago Medical School in 1953.

***Stray, David,** Dolton, died January 24, at the age of 62.

***Wasick, Milan M.,** Oak Lawn, died January 25, at the age of 72. He graduated from the University of Illinois in 1937.

***Woitalewicz, John Paul,** Park Ridge, died January 25, at the age of 83. He was on the staff of St. Elizabeth's Hospital until his retirement in 1965.

**Denotes member of ISMS*
***Denotes member of 50-year Club and ISMS*



BLUE SHIELD REPORT FOR *Illinois Physicians*

National Account Membership and Central Certification

The Blue Shield Plan of Illinois Medical Service routinely processes claims for 61 National Accounts under a Central Certification system. As the name implies, Central Certification is a method of certifying employees' eligibility and program utilization against a master membership file held by the Control Plan (Home Plan).

Each of the Blue Shield Plans across the country with members belonging to the National group report membership status and utilization of program benefits to the Control Plan. All the participating Blue Shield Plans similarly contact the Control Plan on membership eligibility and utilization.

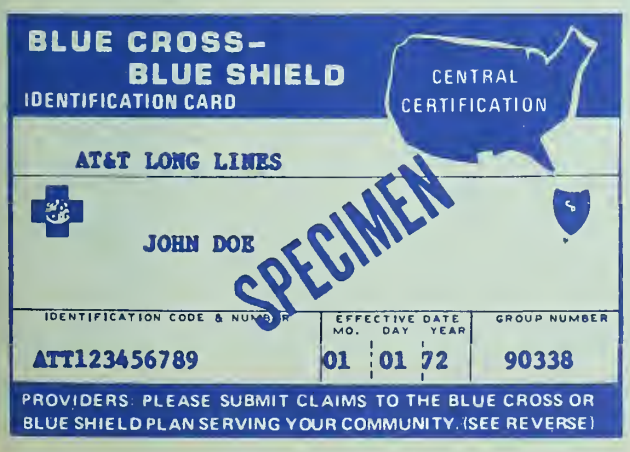
The Control Plan of a National Account may call upon us for assistance in establishing the necessary professional relations with physicians in the recognition and acceptance of National Account Identification Cards presented by employees of a large corporation covered by a national group benefit program.

A recent example involved the National Account of American Telephone and Telegraph Co's Long Lines Department.

The group benefit program for AT&T's employees is one of the most comprehensive of many health care contracts written by Blue Cross-Blue Shield for national corporations to protect their employees.

Employee coverage has been continually improved by expanding the benefits of its program. In the original AT&T contract, for example, reimbursement for surgical-medical services was on a limited Indemnity basis. Now coverage for these services is paid at 80% of physicians' Usual & Customary charges, with the patient responsible for the difference. Other benefit improvements and additions have been made since the contract has been in effect.

AT&T employees are enrolled under our Central Certification system, and their benefit eligibility can be quickly determined by Illinois Medical Service. When a patient presents an AT&T membership identification card you may be assured of the validity of his enrollment because it will be checked by us and payment for services will be promptly processed.



ID Card Easily Recognized

Each AT&T Long Lines employee receives a Blue Cross and Blue Shield Identification Card assuring the employee or dependent he will receive uniform benefits wherever and whenever he may need the services of a physician. The card is easily recognized by the wording "Blue Cross-Blue Shield Identification Card" across the top, with "Central Certification" in the outline map of the United States in the upper right portion of the card. (Sample of the card is shown). The name of the employer shows prominently on the card, with the identification code number, effective date of coverage and the Group Number.

Following the alphabetical code ATT is the employee's Social Security Number, e.g. ATT 123-45-6789. The Group Number is 90338.

When you file a claim for a patient holding such a card, please complete our regular Blue Shield Physician's Service Report form in the usual manner and send it to us—Illinois Medical Service, 233 N. Michigan Ave., Chicago, Illinois 60601. Please be certain you enter the Group Number 90338 followed by ATT and the employee's Social Security number. Without this information payment for covered benefits will be delayed. Your cooperation will be appreciated.

(This report is a service to the physicians of Illinois)

SUMMARY OF LIMITATIONS ON REASSIGNMENT OF BENEFITS

A provision in the Medicare amendments enacted in 1972 and effective with claims filed after October 30, 1972 limits the circumstances under which a physician may reassign payment of benefits. Prior to the amendment, there was no provision in the law allowing or prohibiting the reassignment of benefits. Because of administrative and payment problems that were created, reassignment was permitted only in certain limited situations and under specified restrictions.

Conditions and Circumstances Established

The new provision continues to prohibit the assignment of benefits to anyone other than the physician who furnished the services, but does establish the conditions and circumstances under which reassignment is permitted. These are:

(1) To the employer of the physician who furnished the service, if the physician is required as a condition of his employment to turn over his fee for service to the employer. (The right of the employer to receive payment is established on the basis of a written contract of employment, or written statement signed by the employer and physician that this is a condition of employment);

(2) To the facility in which the service is provided if there is a contractual arrangement between the facility and the physician furnishing the service, and the billing is done by the facility. (Medicare's present definition of a "facility," under the reassignment rule is limited to institutions that furnish services to inpatients. It may be a hospital, skilled nursing facility, nursing home, home for the aged or other institution of a similar nature. The arrangement may apply to all services or only to a particular category of services);

(3) To a foundation, plan or similar organization which furnishes health care through an organized delivery system if there is a contractual agreement between the organization and the physician furnishing the service, and which bills for the service.

(Examples of this type are a medical group clinic and a prepaid group practice plan. The physician must be associated with such an organization, but the services need not be rendered within the health care system and under the direction of the organization. Payment is made to an organization of this type on a reasonable charge basis).

Further information on limitations on reassignment of benefits is available by writing to Blue Shield Plan of Illinois Medical Service, Professional Relations Department, 233 North Michigan Ave., Chicago, Illinois 60601.

Higher Part B Medicare Premium Rate Effective July 1, 1974

Notices with Social Security benefit checks mailed to Medicare beneficiaries in March announced the increase in Part B Medicare premium rate to $6.70 per month, 40 cents higher each month than the current premium. The new rate is effective from July 1, 1974 through June 1, 1975. A reminder with the July 3 Social Security checks will advise beneficiaries that the higher Part B premium was deducted from that check. The Part B deductible was increased January 1, 1973 from $50 to $60.

The Social Security Administration estimates that 22.9 million persons will be enrolled in Medicare's supplementary medical insurance program in fiscal 1974, including 1.7 million disabled persons under age 65 covered by 1973 legislation and those needing treatment for chronic kidney disease who meet the basic requirements for Social Security benefits.

Part A Deductible and Coinsurance Amounts Increased Earlier

The Part A deductible and coinsurance amounts for inpatient hospital services and Skilled Nursing Facilities were increased for benefit periods beginning January 1, 1974. The new inpatient deductible is $84.00 and coinsurance amounts are $21.00 per day for the 61st through 90th day, $42.00 per day for each lifetime reserve day and $10.50 per day for the 21st through 100th day of inpatient Skilled Nursing Facilities services.

SSA Changes in Lab Certifications

The Social Security Administration has approved the following laboratory for participation in the Medicare program:

26th Street Medical S.C. Laboratory
3814-26th Street
Chicago, Illinois 60623
Provider Number: 14-8262

The laboratory listed below has changed its name, ownership and location:

Beverly Sheridan Laboratory, formerly at 9449½ South Ashland Avenue, Chicago, Illinois is now:

Evergreen Sheridan Laboratory
9760 South Kedzie Avenue
Evergreen Park, Illinois 60642

It has retained its Provider Number: 14-8103.

IMJ
Illinois Medical Journal

APRIL, 1974 Vol. 145, No. 4 CONTENTS

366 Abstracts of Board of Trustees Meeting

Special Articles

326 "Snap Crackle and Pop!"

348 Control of Habit Forming Drugs

350 Prescribing Physical Therapy

Clinical Articles

315 Forearm Replantation
A Case Report of a Two-Year Follow-Up
Z. J. Bilos, M.D.; Harold Labinsky, M.D.; and Hassan Khazie, M.D.

317 Hemofiltration for Schistosomiasis Japonicum
W. Stuart Battle, M.D.; Lloyd M. Nyhus, M.D.; and C. Thomas Bombeck, M.D.

322 Drugs in the Management of Learning and Behavior Disorders in School Children
J. Gordon Millichap, M.D.

324 Angiosarcoma of the Liver
Timothy G. Lee, M.D.; and A. G. Lawrence, M.D.

335 Pediatric Perplexities: Simple Fluoroscopic Studies For Upper Airway Problems
Vivian J. Harris, M.D.; and Wrophas Meeks, M.D.

352 Treatment of Children With Burns
John G. Raffensperger, M.D.; and William J. Pokorng, M.D.

Surgical Grand Rounds

338 Parietal Cell Vagotomy
John M. Beal, M.D., Editor

(Contents continued overleaf)

Features

300 President's Page
312 Clinics for Crippled Children
333 Viewbox
334 EKG of the Month
343 Doctor's News
358 Editorial
362 Pulse of the Doctor's Wife
364 ISMS Guide to Continuing Medical Education
366 Illinois Society, American Association of Medical Assistants
370 Physicians Recruitment
373 Obituaries
375 Classified

(Cover by Mike Ahearn)

Staff

Editor **Theodore R. Van Dellen, M.D.**

Managing editor **Richard A. Ott**

Assistant editor **Joyce Gallagher**

Executive administrator **Roger N. White**

PUBLICATIONS COMMITTEE

Jacob E. Reisch, M.D., Springfield, *Chairman*
Eugene T. Hoban, M.D., Oak Park
Frederick E. Weiss, M.D., Harvey
James A. McDonald, M.D., Geneva
Warren W. Young, M.D., Crete

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Medical Progress: Harvey Kravitz, M.D., Skokie
Contributor in Maternal Death Studies:
Robert Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth A. Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood

ILLINOIS STATE MEDICAL SOCIETY

360 N. Michigan Ave., Chicago, 60601

OFFICERS

Willard C. Scrivner, M.D., President
6600 West Main, Belleville 62223

Fredric D. Lake, M.D., President-Elect
1041 Michigan Avenue, Evanston 60202

Paul W. Sunderland, M.D., 1st Vice-President
214 N. Sangamon St., Gibson City 60936

Charles J. Weigel, M.D., 2nd Vice-President
7579 Lake Street, River Forest 60305

Jacob E. Reisch, M.D., Secretary-Treasurer
1129 S. 2nd Street, Springfield 62704

HOUSE OF DELEGATES

Andrew J. Brislen, M.D., Speaker of the House
6060 S. Drexel Blvd., Chicago 60637

James A. McDonald, M.D., Vice-Speaker
13 South Second Street, Geneva 60134

TRUSTEES

Chairman of the Board: William M. Lees, M.D.
6518 North Nokomis, Lincolnwood 60646

1st District: 1974, Joseph L. Bordenave, M.D.
1665 South Street, Geneva 60134

2nd District: 1974, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364

3rd District: 1976, David S. Fox, M.D.
20829 Greenwood Center Court, Olympia Fields 60461

3rd District: 1976, Robert T. Fox, M.D.
2136 Robin Crest, Glenview 60025

3rd District: 1975, Eugene T. Hoban, M.D.
6429 North Avenue, Oak Park 60302

3rd District: 1975, Joseph H. Skom, M.D.
707 Fairbanks Ct., Chicago 60611

3rd District: 1974, William M. Lees, M.D.
6518 North Nokomis, Lincolnwood 60646

3rd District: 1974, George Shropshear, M.D.
1525 East 53rd Street, Chicago 60615

3rd District: 1974, Philip G. Thomsen, M.D.
13826 Lincoln Avenue, Dolton 60419

3rd District: 1976, Frederick E. Weiss, M.D.
15643 Lincoln, Harvey 60426

3rd District: 1975, Warren Young, M.D.
3450 Haweswood Drive, Crete 60417

4th District: 1976, Fred Z. White, M.D.
723 North 2nd Street, Chillicothe 61523

5th District: 1976, A. Edward Livingston, M.D.
326 Fairway Drive, Bloomington 61701

6th District: 1975, Mather Pfeiffenberger, M.D.
State and Wall Streets, Alton 62002

7th District: 1976, Arthur F. Goodyear, M.D.
142 East Prairie, Decatur 62523

8th District: 1976, Eugene P. Johnson, M.D.
P.O. Box 68, Casey 62420

9th District: 1975, Warren D. Tuttle, M.D.
203 North Vine Street, Harrisburg 62946

10th District: 1975, Herbert Dexheimer, M.D.
301 S. Illinois, Belleville 62220

11th District: 1974, Joseph R. O'Donnell, M.D.
444 Park, Glen Ellyn 60137

Trustee-At-Large: Frank J. Jirka, Jr., M.D.
1507 Keystone, River Forest 60305

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/ Clinical Practice.*

Published by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601 (312-782-1654)

Copyright, 1974. The Illinois State Medical Society.

Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail).

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.



Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

takes care of the gut issue in irritable colon

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL* IS NOT *AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co., Medical Department
Box 5110, Chicago, Illinois 60680



President's Page

We Must Write Next Chapter of Anti-Substitution Saga

The next chapter in what promises to be a long book—the story of efforts to repeal anti-substitution laws—will be written during the current session of the General Assembly.

The latest installment, authored by Rep. John Matijevich (D., North Chicago), calls for amendment of the Pharmacy Practice Act to allow pharmacists to substitute an "equivalent" drug unless the physician directs otherwise in writing.

Although the intent of House Bill 2136 is to permit substitution, it will be difficult to shout it down over the anticipated clamor of support by consumer groups, the Illinois Pharmaceutical Association and, surprisingly, the Illinois Department of Public Health.

Some supporters contend that the proposal does not erode a physician's prescribing authority since he would retain the option to block substitution. And, of course, we are beleagured by statements from many quarters claiming that an "equivalent" drug is as effective—and less expensive—than a specific brand-name product.

To argue that all brand-name drugs within a "generic family" are equivalent is similar to arguing that all individuals within the generic term "patient" are equivalent. The "generic" theory already has been dispelled by numerous research studies which revealed that biological differences in supposedly equivalent drugs can alter the efficacy of the physician's prescribed therapy.

Also, those who maintain that the FDA's regulatory and testing capabilities guarantee the competence of each drug are resting their case upon a shaky foundation. The FDA is critically short of manpower and simply cannot assure equivalency among pharmaceutical producers or products.

Interestingly, the legislative activity is Springfield follows closely upon the heels of an HEW proposal to limit government reimbursement for Medicare-Medicaid prescription drug expenses to the least costly generic drug available.

At first glance the proposed regulations appeared to be a step toward providing first-class medical care at reduced cost. A closer look revealed, however, that the move would force two alternatives upon Medicaid-Medicare beneficiaries: accept inferior products or pay the difference in the cost of prescribed medication—thus increasing the cost of medical care for those able to afford it.

HEW backed off last month when it became apparent that the proposal might curb research and quality control programs of major drug companies confronted by a "price war" with some smaller, and perhaps less reliable, manufacturers.

HEW now is considering an alternative ceiling-price policy which would focus somewhere near the middle ground of the drug price scale; broad enough to include some brand-name products, but restrictive enough to possibly encourage major firms to manufacture products less expensive than their brand names. The potential danger of this proposal could be inferior drug products for beneficiaries of government programs.

In effect, HEW has made itself vulnerable to charges of encouraging the development of "back room" operations which ignore research and quality control. Ironically, an earlier chapter of the anti-substitution story tells how counterfeiting of drugs by "back room" firms and unethical substitution by some pharmacists prompted passage of the original anti-substitution laws in the 1950s.

Another early chapter reveals that major supporters of the first anti-substitution laws were the American Pharmaceutical Association (APHA) and its component state organizations. Arguing for enactment of the legislation, the associations claimed that it was needed to protect the public. However, a later chapter relates how the associations did a complete turnabout in 1971 and unleashed a high-powered campaign to permit substitution. What, if anything, occurred to eliminate the need for this protection?

Although that question has not been answered, the APHA and Illinois Pharmaceutical Association now claim that anti-substitution laws make the pharmacist's function more mechanical than professional. This view apparently was prompted by advances in pharmaceutical manufacturing which generally have made it unnecessary for druggists to compound prescriptions.

Illinois anti-substitution law was passed only

(Continued on page 361)

Joint Statement on Antisubstitution Laws and Regulations

The purpose of this statement is to affirm the support of the participating organizations for the laws, regulations and professional traditions which prohibit the unauthorized substitution of drug products.

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interests of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare.

The antisubstitution laws have not obstructed enhancement of the professional status of pharmacy any more than they have in and of themselves guaranteed absolute protection from unsafe drugs, or freed physicians, dentists and pharmacists from their responsibilities to patients. As a practical matter, however, such laws and regulations encourage interprofessional communications regarding drug product selection and assure each profession the opportunity to exercise fully its expertise in drug usage, to the advantage of patients.

Physicians and dentists should be urged to increase the frequency and regularity of their contacts with pharmacists in selection of quality drug products, recognizing that economies to patients can be improved through such communication, taking into account the patients' needs. The pharmacist's knowledge of the chemical characteristics of drugs, their mode of action, toxic properties and other characteristics that assist in making drug selection decisions should be utilized to the fullest extent practicable by physicians and dentists in serving their patients.

Since drug product selection entails knowledge derived from clinical experience, the physician's and dentist's roles in product selection remain primary and do not permit delegation of decisions requiring medical and dental judgments. A broader role in therapy will evolve for pharmacists as improved understanding and cooperation among the professions continue to grow.

There has been no evidence that there are convincing reasons to modify or repeal existing laws and regulations prohibiting the unauthorized substitution of another drug product for the one specified by a prescriber. It is our belief that such laws and regulations merit the joint support of the medical, dental and pharmaceutical professions and the pharmaceutical industry.

Add your opinion to the weight of other professionals and send it to your state assemblyman or legislator.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D. C. 20005

Abstracts of Board of Trustees Meeting

February 3-5, 1974

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

Special Session of House of Delegates Called

By a majority vote of the Board of Trustees, a special session of the House of Delegates had been called to re-evaluate the ISMS position on Professional Standards Review Organizations. The session was to be at 9:30 a.m., Sunday, Feb. 24, at the McCormick Inn, 23rd St. and Lake Shore Drive, in Chicago. All PSRO-related resolutions submitted for the regular session of the House in April were to be mailed to delegates and alternates in advance of the special session.

1974 Budget Approved

A $1,123,045 balanced budget was presented by the Finance Committee and approved by the Board. It was reported that ISMS ended 1973 with a $20,858 surplus, due largely to increased membership in the Chicago Medical Society. The Board commended CMS for its recruiting efforts and noted that it caused ISMS to have the largest numerical membership increase of any state last year. Twelve percent of all new AMA members came from CMS last year.

Woman's Auxiliary

Upon recommendation of the Advisory Committee to the Woman's Auxiliary, the Board approved an increase in the ISMS Auxiliary dues from $8 to $10 a year. If approved by the Auxiliary's House of Delegates in April, this will be the first increase in Auxiliary dues since 1959. In view of the anticipated success of the Auxiliary's Health Education Workshop, to be held Feb. 28, the Board agreed in principle to approve a similar program to be conducted in 1975. ISMS contributed $2,500 to this year's workshop.

Legislation

The Board endorsed proposed legislation on acupuncture based on the following premises: (1) Only physicians licensed to practice medicine in all its branches—and dentists—may use acupuncture; (2) Acupuncture should be performed in a controlled setting, appropriate for the conduct of research, including private practice, when the procedure is performed according to accepted protocols; and (3) Patients must give informed consent.

It also endorsed the concept of mandatory inclusion of new borns in any health insurance policy which provides maternity benefits and instructed the Governmental Affairs Council to support suitable legislation if introduced.

The Board opposed an American Cancer Society program to train paramedical personnel in performing PAP smears and uterine cytologic examinations on hospitalized female patients as provided in HB 319 which was signed into law last year. ISMS will notify the Cancer Society of its position.

Following are Board actions on pending bills:

HB 1922—Amendment to Illinois Nursing Act which, in effect, paves the way for utilization of physician assistant services. The Board deferred action and directed the Council on Social and Medical Services to develop a position statement on nurses performing diagnosis and treatment.

HB 2136 and 2137—Seek repeal of Anti-Substitution Law. ISMS opposes.

HB 2098—Prohibition of Subrogation Clauses with respect to Medical payments. ISMS takes no position.

HB 2121—Amendment to Illinois Nursing Act allowing those who have fulfilled all requirements to be a practical nurse, except for passing the written exam, to engage in practical nursing under certain limited conditions. ISMS supports.

HB 2077—Code of Corrections. ISMS will not support this bill and will work to have it held since it will be reviewed by the new Commission on Revision of the Mental Health Code.

HB 751—Human Experimentation Act. ISMS supports the bill with amendments proposed by the Medical-Legal Council.

Promotion of Family Practice

ISMS will initiate a resolution in the General Assembly calling for all Illinois medical schools to report their activities in the area of encouraging and promoting to medical students the specialty of family practice.

Confidentiality

The Board requested legal counsel to review the laws of Illinois as applied to physician-patient records. If it is found that the law is ambiguous in language and application, legal counsel will prepare a proposal to rectify the situation.

Hospital District Boards

Legal counsel also was directed to prepare proposed legislation amending the present Hospital Licensing Act, to allow physicians to serve on the board of directors of a hospital district.

Development of Nutrition Centers

The Board endorsed a proposed legislative resolution developed by the Council on Social and Medical Services calling for establishment of nutrition education centers around the state.

Medical Information on Drivers' Licenses

ISMS will discourage the Secretary of State from placing medical information on drivers' licenses. Instead, it will be recommended that licenses should include a space for the driver to write in his own medical information.

Emergency Medical Service

Information on the establishment and accreditation of training courses for emergency medical personnel will be publicized in the *Illinois Medical Journal* and "Action Report." In a related action, the Board will demand that the Illinois Department of Public Health require local emergency medical service councils and committees to include in their membership an elected representative from each of the participating hospital medical staffs or the local medical society.

Consumer Appointments to Licensing Boards

The Board will immediately file suit to block the illegal appointment of a consumer to the Medical Examining Committee if such an appointment is made. The action resulted from reports that the Consumer Advocate in the Governor's office plans to appoint consumers to state licensing boards. The Medical Practice Act specifies who may sit on the Medical Examining Committee.

Alcoholism and Drug Abuse

The Board endorsed a new definition of alcoholism, which will be presented to the House of Delegates, and approved plans for an early fall symposium on alcoholism and drug abuse to be conducted in cooperation with the Illinois Drug Abuse Program, National Training Center on Drug Abuse, the Illinois Psychiatric Society, and the local county medical society. Plans are contingent upon obtaining adequate funding.

Limited License Physicians

The Council on Mental Health and Addiction will introduce a resolution in the House of Delegates in April calling for legislation which would allow certain limited licensed physicians to continue practicing in state hospitals until January, 1978. The present law permitting this practice will expire in June, 1975. The Board indicated that it would not endorse the resolution, but would not prevent it from being introduced.

Arbitration Project

The Board approved expenditures up to $2,500 for initial funding of the Pilot Project of Voluntary Arbitration of Professional and Institutional Medical Malpractice Claims and authorized legal counsel to meet with attorneys from the Illinois Hospital Association, American Arbitration Association and Chicago Bar Association to determine the scope and nature of any discovery proceedings to be made part of the project.

Amendments to Bylaws

Three proposed amendments to the bylaws were approved by the Board for presentation to the House of Delegates in April; the amendments are:

1. Deletion of full-time AMA employees from the Service Member category and provision for membership by these physicians who may not be licensed in Illinois.
2. Deletion of the requirement that the Board of Trustees have a standing Committee on Committees.
3. Provision for the secretary-treasurer to temporarily assume the responsibilities of the Chairman of the Board of Trustees in the chairman's absence or illness.

Two other matters were referred back to the Committee on Constitution and Bylaws—a recommendation that the age for emeritus status not be lowered from 70 to 65 and the instruction to obtain additional legal advice on clarifying the responsibilities of the Council on Economics and Peer Review in the appeals process. The proposed revision of Chapter VIII of the bylaws, which would create district organizations, will be discussed in district caucuses prior to the regular sessions of the House of Delegates.

Family Health Records

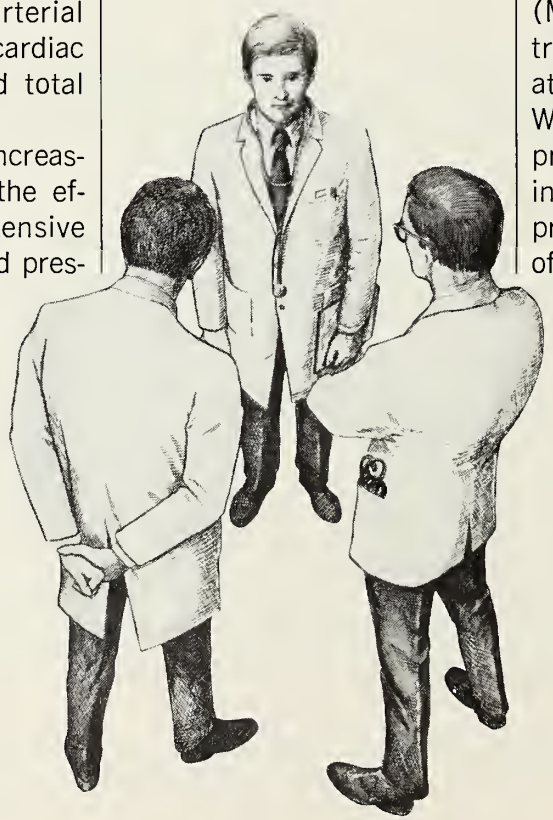
The Board approved a recommendation that the Illinois Hospital Association's Family Health Record be endorsed in principle in its present form.

(Continued on page 367)

The more physicians consider the hemodynamics of lowering blood pressure...

Most physicians now agree on the importance of reducing blood pressure in the hypertensive patient. But high blood pressure exists, of course, only as part of a complete clinical picture. The hemodynamic profile of well-established essential hypertension is characterized by elevated arterial blood pressure, normal cardiac output, and increased total peripheral resistance.

And so, physicians are increasingly concerned with the effects of an antihypertensive agent not only on blood pressure itself but also on the hemodynamic pattern—in short, with the total effect of the drug. *Does* it indeed help lower blood pressure effectively? *Is* peripheral resistance reduced? *Are* cardiac output and renal functions maintained? And, also, is there likely to be drug-induced postural hypotension serious enough to pose a threat to the patient's cerebrovascular status?



With this emphasis on overall drug performance has come a growing reliance on ALDOMET® (Methyldopa, MSD) in the treatment of sustained moderate hypertension.

With its unique hemodynamic profile, ALDOMET has drawn increasing attention and approval from physicians. First, of course, for its efficacy in

Holiday Inn, Rochester Downtown. We're here to ease the stress factor.

No one needs to be told that a trip to the hospital--even one so highly respected as the clinic--can be a distressing experience. It's also common knowledge that familiar, amenable surroundings can reassure a patient psychologically, and thereby promote a more rapid recovery.

Holiday Inn Downtown provides the clinic out-patient with such an environment. Our service and accommodations are pleasant, warm, relaxed, and geared precisely to meet the needs of visitors to the clinic. And we offer free, 24-hour transportation service to and from the clinic.

Next time you (or your patient) comes to Rochester, think of us. You might find a place a few steps closer to the clinic. But you won't find one closer to home.

Holiday Inn - Rochester Downtown

HOLIDAY INN--ROCHESTER DOWNTOWN
220 S. Broadway
Rochester, Minn. 55901
(507) 288-3231

Crippled Children Clinics Listed for May

Thirty-one clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 23 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

May 1 Hinsdale—Hinsdale Sanitarium
May 2 Sterling—Sterling Community Hospital
May 2 Litchfield—St. Francis Hospital
May 2 Effingham—St. Anthony Memorial Hospital
May 2 Lake County Cardiac—Victory Memorial
May 6 Peoria Cardiac—St. Francis Children's
May 7 Belleville—St. Elizabeth's Hospital
May 7 Fairfield—Fairfield Memorial Hospital
May 8 Joliet—St. Joseph's Hospital
May 8 Champaign-Urbana—McKinley Hospital
May 9 Springfield—St. John's Hospital
May 9 Macomb—McDonough District Hospital
May 10 Chicago Heights Cardiac—East Chicago Heights Community Center, Inc.
May 14 Peoria—St. Francis Children's
May 14 East St. Louis—Christian Welfare Hospital
May 15 Evergreen Park—Little Company of Mary Hospital
May 16 Rockford—Rockford Memorial
May 16 Pittsfield—Illini Hospital
May 16 Elmhurst Cardiac—Memorial Hospital of DuPage County
May 20 Peoria Cardiac—St. Francis Children's
May 21 East St. Louis—Christian Welfare Hospital
May 21 Rock Island—Moline Public Hospital
May 21 Decatur—Decatur Memorial Hospital
May 22 Centralia—St. Mary's Hospital
May 22 Springfield Ped-Neurology – Diocesan Center
May 22 Chicago Heights—East Chicago Heights Community Center, Inc.
May 22 Elgin—Sherman Hospital
May 23 Anna—Union County Hospital
May 24 Chicago Heights Cardiac—East Chicago Heights Community Center, Inc.
May 28 Peoria—St. Francis Children's
May 29 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults ◄

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.

WC **WARNER/CHILCOTT**
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

PR-GP-31-6/W

IMJ
Illinois Medical Journal
Vol. 145, No. 4, April, 1974

Forearm Replantation

A Case Report of a Two-Year Follow-up

By Z. J. Bilos, M.D.; Harold Labinsky, M.D.; and Hassan Khazie, M.D./Elk Grove

A 21-year-old male was brought to Alexian Brothers Medical Center, March, 1970, after an industrial injury during which the amputation of his right forearm was caused by the sharp blade of an industrial paper cutter. The amputation was therefore a clean transection with practically no crushing or embedding of debris. Because of this circumstance and the patient's age and good health, it was decided to perform a replantation.

The distal portion was placed in ice; the ulnar and radial arteries were cannulated and irrigated with a saline Heparin solution beginning about 45-minutes after amputation. The surgical procedure was performed under general anesthesia. The bones were shortened one centimeter. They were reattached by intermedullary Rush rods. The radial and ulnar arteries, as well as the anterior interosseous artery, were anastomosed. After the arteries were united, two superficial veins, the cephalic and the basilic, were likewise anastamosed. The tendon and intermuscular fascial layers were approximated with silk sutures. Direct suture of the radial nerve was performed, but the ulnar and median nerves were overlapped approximately one centimeter and fixed to the peripheral tissues. Heparin was given intravenously during the procedure and four units of blood were required. The arterial anastomoses were completed within three hours of the amputation. (Figure 1)



Figure 1. Forearm before vascular anastomosis.

Postoperatively the circulation remained good. There was less swelling of the fingers than in an average case of adult forearm fracture. An area of skin on the dorsoulnar aspect approximately four centimeters square based on the incision became edematous and eventually sloughed. Split thickness skin grafts were used to cover the area in April, 1970. Ten days later the median ulnar nerves were rejoined. The distal portion of the

Z. J. BILOS, M.D., an orthopedic surgeon, is on staff at Alexian Brothers Medical Center, Elk Grove. Dr. Bilos studied orthapedics at the St. Louis University Haspital and was a Hond Fellow at the University of Lauisville.

HAROLD C. LABINSKY, M.D., is the Chief of Surgery and General Surgeon at Alexian Brothers Medical Center, Elk Grove. Dr. Labinsky is o Fellow af the American Callege of Surgery and o member of the Committee an Trauma, American College af Surgeons.



Figure 2. Forearm–two years later.

nerves was softened. The perineurium tended to tear easily and the nerves separated into neurofibrils readily. Despite the previous overlap, a gap of at least one inch existed after the necrotic distal portion of the nerves was debrided. This was overcome by mobilization and by flexion of the wrist. At the time of this exploration the ulnar artery was found to be thrombosed.

Following the last procedure, a portion of the ulnar incision sloughed and a 1½ x 1 centimeter open area left the ulnar nerve exposed. This required a local rotation flap foreclosure in June, 1970. Before and after surgery, the patient was treated with appropriate antibiotics. He was seen periodically for another four months. During this time he was gradually overcoming the flexion contracture of the wrist which developed following the nerve suture. At this point, however, the patient was lost to follow-up for about two years.

The next and last examination was in May of 1972. Figures two and three illustrate the findings at this examination. The patient is now a salesman. He uses his hand as a helping hand only. He feels that it is much better than a prosthesis, even though it is perhaps less functional. He has good protective sensation over the forearm, the hand, and the fingers, and can differentiate sharp form dull in all areas except over the tip of the thumb. The wrist is ordinarily kept at 50° of flexion. He is able to extend it passively another 10°. The metacarpal and phalangeal joints are essentially immobile in their fully extended position. The thumb is adducted opposite the index and middle fingers. There is no active extension of any of the digits or the wrist. The proximal/interphalangeal joints passively extend 45° from their 90° flexed position. When attempting voluntary flexion, a mass movement of the wrist and finger flexors occurs, but the only discreet motion is a flexion of the thumb. The thumb, however, is not able to touch any of the fingers. The radial pulse is strong and there are no ulcerations in the skin. X-rays at this time (Figure 4) revealed complete healing of the radius. However, there is an area of bone loss in the ulna which is in the area of previous drainage and sloughing.



Figure 3. Forearm–two years later.



Figure 4. X-ray of forearm at two years following. There is non-union and bone loss at the ulnar fracture site.

Discussion

The decision to perform a forearm replantation is difficult. In this situation, the type of amputation, as well as the patient's age and general health, were ideal. The patient has, as a result, a hand with sensation and a relatively satisfactory appearance. The motor function of the hand, however, is poorer than what might have been possible with a prosthesis. On the whole, the patient is satisfied and grateful.

As far as technique is concerned, bone stabilization by Rush rod is simpler, quicker, and less destructive than a plate and screw application. Nerve repair, if at all possible, is much easier during the first procedure. Perhaps the skin slough as well as slough of the extensor musculature would not have occurred if vein and artery anastomosis had been possible on the dorsal aspect of the forearm.

Forearm replantation as well as the amputation is a difficult, stressful situation for the patient physically as well as emotionally. After the procedure he has to expect possible loss of the limb, other operations, rehabilitation procedures, undue publicity, compensation problems and a new life style.

Summary

This paper is a report of a two-year follow-up on a forearm replantation in a 21-year-old male.

(Continued on page 360)

Hemofiltration For Schistosomiasis Japonicum

By W. Stuart Battle, M.D., Lloyd M. Nyhus, M.D., and
C. Thomas Bombeck, M.D./Chicago

It has been estimated that schistosomiasis is now the most important parasitic disease in the world. Previously, it was second only to malaria, but since the risk of malaria has been drastically reduced for at least 77% of the population of previously malarious areas,[1] schistosomiasis has assumed the dubious honor as the leader. The oriental form, Schistosomiasis japonicum, has resulted in over 60 million infections with over 150 million exposed.[2] Since the cases in America have been rare (with the exception of 1943 when 3,000 American servicemen contracted the disease in the Philippines), it has attracted little attention. In 1967 Goldsmith reported a method of hemofiltration to reduce the worm burden of the disease.[3] This method was initially used for cases of Schistosomiasis mansoni prevalent in the Puerto Rican community in New York City, but later experience demonstrated that the species S. japonicum was also amenable to this form of treatment.[2]

The purpose of this paper is to report our single experience with this method of treatment at the University of Illinois Medical Center.

Case Report

First Admission.

History: A 25-year-old Laotian graduate student at Southern Illinois University at Carbondale was admitted to the University of Illinois Hospital for the first time on July 12, 1972. He was referred from Memorial Hospital in Carbondale, where the diagnosis of Schistosomiasis japonicum with portal hypertension and esophageal varices had been made. The purpose of the referral was for confirmation of the diagnosis and management. His present illness had begun in April, 1971, when he experienced the first episode of hematemesis and melena. He was hospitalized and all investigations were nondiagnostic at that time, and a presumptive diagnosis of duodenal ulcer was made. He was recalled to the hospital when laboratory reports confirmed an elevated alkaline phosphatase and SGOT.

On the second admission, he was found to be anemic and received two units of packed red cells. A percutaneous liver biopsy was obtained, demonstrating Schistosomiasis japonicum ova in the periportal areas and the characteristic "pipestem" fibrosis. A liver scan revealed multiple defects with an enlarged spleen. He was then discharged and referred to the University of Illinois Hospital for treatment. On admission to this hospital, he was essentially asymptomatic except for some periodic moderate lethargy. Past history revealed that on entry into this country he was told that he had a parasitic disease and was given an oral medication. He found this unpalatable and discontinued its use on his own decision.

Physical Examination: On admission, the vital signs were: temperature 98°F.; pulse 76; blood pressure 110/60 (right arm supine); and respirations 16. Examination revealed a thin well-developed young oriental male in no acute distress. Pertinent physical findings were limited to the abdomen where the liver was noted to be enlarged and the spleen was palpable 4-5 cm below the left costal margin.

Hospital Course: An upper gastrointestinal series documented the presence of esophageal varices; liver function studies revealed an elevated alkaline phosphatase, SGOT, SGPT, and ICD. Hepatic wedge pressure was measured and found to be elevated at 22 mm Hg. A review

At the time of writing, the outhors were from the Deportment of Surgery, The Abrahom Lincoln School of Medicine, University of Illinois College of Medicine, Chicogo.

*Supported in part by USPHS Grant No. 11835-05 AM and the Warren H. Cole Society.

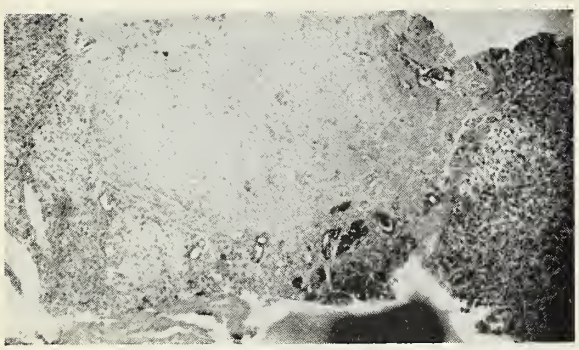


Figure 1. Liver biopsy specimen demonstrating a granuloma of the liver with calcified S. japonicum ova in the adjacent venules.

of the histologic slides of the previous liver biopsy confirmed the initial diagnosis of Schistosomiasis japonicum. (Figures 1, 2, 3) He was discharged to be readmitted at a later date for portal venous hemofiltration.

Second Admission

Approximately one month later, he was presented to the Emergency Room with a 24-hour-history of having become weak, dizzy, and thirsty. He had experienced nausea but no vomiting. Just prior to admission he had a loose, tarry black stool. On admission the vital signs were: temperature 98°F.; pulse 110; respirations 20; and blood pressure 100/50 (right arm supine). His physical examination was essentially unchanged from that of the previous admission except for the presence of black, guaiac positive stool in the rectum. Laboratory studies revealed again elevated liver enzymes and a BUN of 30 mg%. At endoscopy, esophageal varices and a small pre-pyloric ulcer, neither of which were bleeding, were seen. He was placed on intravenous fluids, an antacid regimen, and ferrous sulfate. He required no blood transfusion, and on this regimen, there was no further bleeding.

When his condition was stable, a rectal biopsy was performed revealing many Schistosoma japonicum ova. Several days later, extracorporeal hemofiltration via the umbilical and femoral veins was attempted. Due to difficulty in cannulating the umbilical vein, this attempt failed. The following day, a splenectomy was performed and the splenic vein cannulated. This time a successful extracorporeal hemofiltration was accomplished recovering 45-50 adult worms. He experienced an uneventful postoperative course and was discharged one week later.

Details of the Extracorporeal Hemofiltration

Through a left subcostal incision, a splenectomy was carried out. A #2 Bardic venous perfusion catheter was placed in the enlarged splenic vein and passed to the junction of the splenic and superior mesenteric veins. A #16 Fr catheter was inserted into the left femoral vein via the saphenous. The patient was systemically heparinized, the roller pump primed with heparinized saline, and the catheters connected to the pump lines. Two wire mesh filters were placed in series between the patient and the pump. (Figure 4) Filtration was begun at a flow rate of 1100 ml/min. The filtration was carried out for 15 minutes, and when all was stable, Tartar emetic (antimony potassium tartrate) 2 mg/Kg was given slowly by the intravenous route. The filtration was then continued for one hour following administration of this drug. Approximately 50 adult worms were recovered, most of which were on the proximal screen.

Third Admission

Six months later he was readmitted for routine evaluation. An upper gastrointestinal series this time demonstrated no esophageal varices. Stool samples were free of ova; his liver enzymes remained slightly elevated, but were lower than the previous values.

Discussion

As previously mentioned, human schistosomiasis is an ubiquitous disease. Of the Schistosomes which infest man, the species mansoni, japonicum and hematobium are the most important. Of these three human species, S. japonicum is fortunately the least prevalent in this country since it is the most difficult to treat. S. mansoni is the most common of the three schistosomes in the United States and occurs chiefly in the one million Puerto Rican inhabitants of whom 5-10% are infected.[4] S. hematobium is seen very

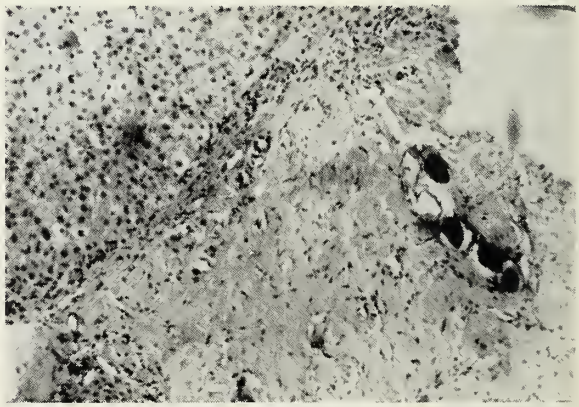


Figure 2. Photomicrograph demonstrating calcified S. japonicum ova in the liver biopsy specimen.

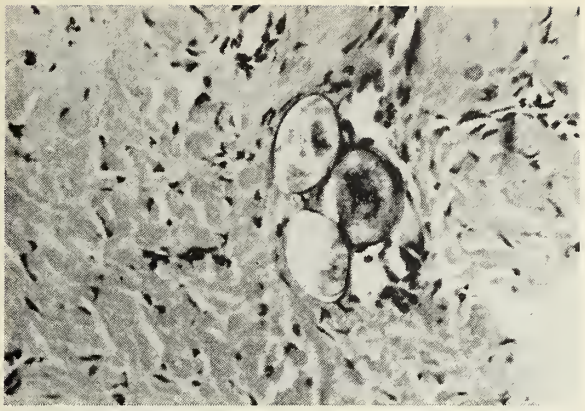


Figure 3. Photomicrograph of S. japonicum ova (non-calcified) ova in liver venule.

rarely in this country.

Foreign exchange students and visitors from endemic areas of Africa, Southeast Asia, South America, and the Middle East account for a small number of cases seen in the United States. Other sources of the disease in this country are American students, foreign emissaries, and most recently, men returning from the conflict in Southeast Asia.

Review of the Disease*

Historically, human schistosomiasis is a chronic disease first described by Theodor Bilharg in 1851. It is caused by three worm species, members of the Class Tremetoda, Phylum Platyhelminthes: 1) Schistosoma mansoni, 2) Schistosoma japonicum, and 3) Schistosoma hematobium. Infection occurs during immersion in fresh water containing schistosome larvae which penetrate the skin and migrate via the lungs and liver to the ultimate habitats of the adult worm, *viz.* the venules of the intestines and urinary bladder. The female adult produces large numbers of eggs (140-3,000 per day depending on the species), many of which remain in the body causing liver, intestinal and urinary tract infections. The adult worms themselves do not multiply in humans. The adult male is 10 mm to 15 mm long and 1 mm in width, while the female is somewhat longer and narrower, being 14-26 mm x 0.2 mm (Figures 5, 6).

The basic life cycle has an alternation of generations with the sexual generation of adult schistosomes in the definitive vertebrate host and an asexual stage in a molluscan host. A relatively short-lived free swimming stage, the miracidium, hatches from the egg and is infective to the snail intermediate host. In the appropriate snail host the miracidium becomes a first-stage sporocyst; this gives rise to second-stage sporocysts which produce numerous free swimming cercariae which are infectious to the vertebrate host. The usual portal of entry is the skin and the cercariae, after penetration, are known as schistosomules. These migrate and develop into mature adult schistosome worms.

The adult worms' habitat in the human varies with the species (Table 1). Initial infection usually occurs in childhood, and reinfection may continue as long as there is contact with fresh water. Complete immunity apparently does not occur. Worms may live for three or more decades, accounting for the chronicity of the disease, and heavy infections are usually established from multiple small exposures.

Table 1

Characteristic Sites of Localization in Man
S. mansoni—inferior mesenteric veins and tributaries.
S. japonicum—chiefly in the capillaries of the superior mesenteric vein or tributaries in the wall of the small intestine but may be present in the portal vein and inferior mesenteric vein.
S. hematobium—veins of the vesical plexus although some may be in the portal vein and mesenteric branches.

In the acute stages (from 3-12 weeks later) symptoms include fever, generalized aches and pains, anorexia, abdominal pain, eosinophilia. Urticaria and puffiness of the eyelids are less frequently reported. The acute stage is more commonly encountered and more severe in infections of S. japonicum and is knows as Katayama fever. This stage is rarely seen in S. haematobium infection in the endemic areas. In S. mansoni infection, the severity of the acute stage is related to the degree of infection. Death rarely occurs at this stage but when it does, autopsy usually demonstrates massive infection.

The severity of the symptoms in the invasive and acute stages varies markedly from individual to individual and is considered to be related more to the degree of sensitization of the patient than to the intensity of the infection.

The chronic stage symptoms (2-4 weeks following acute stage) vary with the location of the adult worm. In S. haematobium the symptoms include dysuria, frequency of micturition, terminal hematuria. In S. mansoni and S. japonicum

**Although a summary of this disease can be found in most thorough medical texts, two are especially excellent in their coverage.*[5,6]

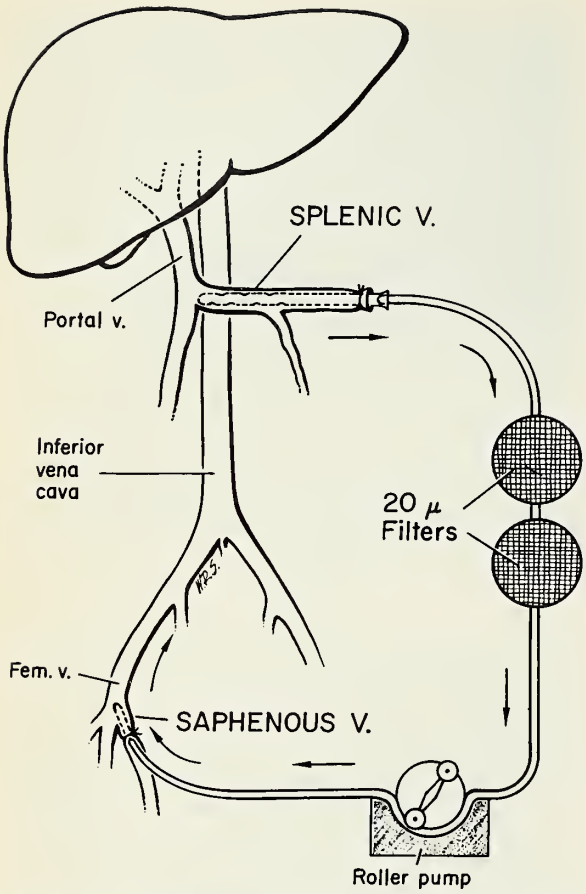


Figure 4. Diagram of extracorporeal circuit used for the filtration of schistosome worms.

infections, symptoms include fatigue, abdominal pain, backache, lethargy, and transient recurring attacks of diarrhea. Patients with few worms may never show any signs of symptoms related to the infection. However, those with large numbers of eggs may progress to have hepatomegaly, splenomegaly, and hemetemesis secondary to bleeding esophageal varices.

S. haematobium infection primarily affects the urinary tract. In the early stage of established infection, subacute inflammation of the bladder wall with edema, tubercles, and papillomata are seen at cystoscopy. The epithelium of the bladder may undergo a number of changes from marked hyperplasia to atrophy. Intractable ulceration of the mucosa and bladder wall has been described but appears to vary with endemic areas. Bacterial infection may occur, spreading rapidly to ureters, kidneys, peritoneum, and pelvic cul-de-sac. Late complications include calcification of the bladder, fibrosed ureters, and subsequent hydronephrosis. Granulomas in the liver are also found, but severe liver damage is not common. The lesions produced by the ova in the lungs produce acute necrotizing endarteritis, leading to healing with fibrocellular thickening of the intima and some occlusion of vessels. As a result, pulmonary hypertension and cor pulmonale ensue.

Although ova of S. mansoni and S. japonicum have been found at autospy in practically all organs, they rarely give rise to symptoms. Depositions in the central nervous system, however, may have serious consequences and spinal cord involvement is more usual with S. mansoni and S. haematobium infections than with those of S. japonicum. There are no signs of schistosomal central nervous system involvement which are specific for the disease or which will confirm the etiology of the lesion.

In S. mansoni and S. japonicum infections, ova are trapped in the mucosa and submucosa of the colon and small intestine. These become centers for granulomatous formations and shallow ulcers may form; sigmoidoscopy may reveal polyps and scars. Caecocolic intussusception, intestinal obstruction, and rectal prolapse may also occur. Infection of the appendix is common. Rarely, the small intestine may be more affected than the large.

In S. mansoni and S. japonicum infections the most serious effect is on the liver. S. Japonicum has a much more rapid and serious course than S. mansoni infection due to the larger number of eggs (approximately 10 times greater) pro-



Figure 5. Adult male and female schistosome worms in copula.

duced by the former. The ova become lodged in the portal tracts and less frequently in the lobules and sinusoids of the liver. This results in inflammatory lesions producing portal and septal fibrosis. The liver parenchyma, however, is not affected.[7] These changes seen in the liver have been termed "pipestem" fibrosis and is characteristic of infections with these species.

Secondary to the portal and septal fibrosis, a form of portal hypertension which is presinusoidal in nature commonly develops. Usually this can be demonstrated by normal wedge hepatic vein pressure (WHVP) with elevated intrasplenic pressure and elevated portal vein pressure, but in the more severe cases, WHVP may also be elevated. This elevated portal pressure may result in esophageal varices with recurrent bleeding; however, it should be noted that this does not carry the same poor prognosis as that of Laennec's cirrhosis since the hepatic parenchyma is not involved. Splenomegaly secondary to portal hypertension may result in hypersplenism.

It should be emphasized in this discussion that the ova which reach the liver incite a granulomatous inflammatory response, but they do not mature into adult worms.

Medical Treatment—Drug Therapy

A complete cure is not always necessary as egg suppression, rather than cure, is the aim of the regimen. Those worms which survive drug therapy do not multiply in the human. Of the three species, S. japonicum infections are the most difficult to control and those of S. haematobium the most responsive. It is still necessary to use the highly toxic antimony compounds to treat S. japonicum infections while the less toxic and more easily administered newer drugs for S. haematobium and S. mansoni infection exist.

Surgical Treatment

As mentioned previously, the surgical treatment of Schistosomiasis mansoni was first described by Goldsmith et al. in 1967.[3] A short time later Kean et al. described the successful treatment of S. japonicum using the hemofiltration technique. Goldsmith's group applied the same technique to three cases of Schistosomiasis hematobium and did not achieve the same degree of success as with the other two species.[8] The exact nature of the failure with this species was unclear. The technique used for the patient in this report was essentially that which Goldsmith described in his initial paper. Kessler et al.[9]



Figure 6. Photomicrograph of the head of adult male schistosome worm.

later described successfully using the umbilical vein to gain access to the portal system under local anesthesia, thus avoiding celiotomy with splenectomy. Our attempt at the latter procedure was unsuccessful due to the passage of the dilating catheter outside the lumen of the umbilical vein.

The theory of extracorporeal filtration for the therapy of human Schistosomiasis is that it removes the adult worm from the host and thus reduces egg production. Since the Schistosomes do not multiply in man, removal of the adult worm may result in a cure of the patient provided he is removed from an endemic area where reinfection is likely. With this technique, portal venous blood is filtered, utilizing an extra-corporeal circuit and returned to the patient via the femoral vein. The adult worms can be mobilized very rapidly from residence in the intestinal venules by intravenous tartar emetic. During mobilization, the worms migrate from the intestinal venules to the liver; this occurs within minutes of the tartar emetic administration, making removal by filtration feasible. Since removal of the worms is the key to therapy, the surgical treatment is the most direct and efficacious means of dealing with the problem.

In the patient presented here, it was obviously desirable to avoid a portosystemic shunt with its potential chronic encephalopathy if at all possible. In addition, a surgically created portosystemic shunt to relieve portal hypertension would have provided a pathway through which most of the subsequent egg production could reach the lung and produce characteristic patho-

(Continued on page 361)

Drugs in the Management of Learning and Behavior Disorders in School Children

By J. Gordon Millichap, M.D./Chicago

The amphetamines were introduced for the treatment of children with hyperkinesis more than 30 years ago by Bradley[1] who discovered their paradoxical quieting effect in patients with hyperactive behavior. Despite the numerous clinical reports on the beneficial response to central nervous system stimulants, controlled studies are limited and there is no satisfactory explanation of the mechanism of action. Reports are conflicting as to the type of hyperkinetic child likely to respond favorably, but most investigators consider that patients with a organic syndrome of minimal brain dysfunction are benefited more than those with primary emotional disorders.

Controlled double-blind studies in school children with hyperactivity and signs of minimal brain dysfunction have shown that treatment with methylphenidate (Ritalin®-Ciba) results in significant, measurable improvements in tests of general intelligence and visual-motor perception[2] Reduction in the level of motor activity was greatest in the most hyperactive children and in those with the largest number of abnormal neurological signs, whereas patients who were only mildly hyperactive were sometimes made worse by methylphenidate.

In another controlled study in a group of emotionally disturbed children, significant improvements in behavior, learning, and maze performance followed a 10-day period of treatment with methylphenidate.[3]

In a review article drug therapy of children with hyperactive behavior and minimal brain dysfunction was analyzed, and the agents were listed in order of choice according to effectiveness and toxicity.[4]

Stimulants. Review of the literature that included adequate data showed that methylphenidate is the drug of choice and amphetamine sulfate (Dexedrine®-Smith, Kline & French) is the second most successful drug. Of a total of 337 patients who received methylphenidate, 84% were benefited, of 415 patients treated with amphetamine, 69% showed improvement in behavior. The daily doses of methylphenidate and amphetamine varied from 5 to 200 mg and 2.5 to 40 mg, respectively. The clinical trials were from one week to a maximum of four years in duration. Untoward effects, including anorexia, irritability, insomnia, and complaints of stomachache occurred in an average of 12% to 14% of the patients treated with either of these stimulants, anorexia being the most troublesome effect in those receiving amphetamine. The stimulant, deanol acetamidobenzoate (Deaner®-Riker) which was less effective than methylphenidate or amphetamine, produced improved behavior in 47% of a total of 239 patients treated. However, no beneficial effects were demonstrated in three controlled studies, and the value of this drug in the treatment of hyperactivity seems doubtful.

Antianxiety and Antipsychotic Agents. Of the antianxiety and antipsychotic agents studied, only chlordiazepoxide (Librium®-Roche), chlorpromazine (Thorazine®-Smith, Kline & French) and reserpine (Serpasil®-Ciba) have been used to treat a sufficient number of hyperkinetic children for adequate comparative evaluation. Hyperkinetic behavior was controlled in 60% of children treated with chlordiazepoxide (237 patients or chlorpromazine (153 patients). Reserpine was less effective and produced improved behavior in 34% of 165 patients.

Antianxiety and antipsychotic agents reported of benefit, but tried in too few patients for adequate appraisal, include thioridazine, hydroxyzine hydrochloride, meprobamate, fluphenazine hydrochloride, and chlorprothixene hydrochloride. Promazine hydrochloride employed in a controlled trial in six mentally retarded children had no significant effect on hyperactivity.

J. GORDON MILLICHAP, M.D., Chicaga, is Prafessar af Neurology and Pediatrics, Narthwestern University Medical Schaal and Neuralagist, Children's Memarial Haspital and Narthwestern Memarial Haspital, Chicaga.

Anticonvulsants. Reports of the efficacy of anticonvulsants in the control of hyperactivity are limited and are concerned primarily with trials in children whose behavior and learning problems are complicated by convulsive seizures. Primidone, found effective in seven of ten patients in one study, has been recommended for use in children with major convulsions and hyperactive behavior, whereas phenobarbital has variable effects and often exacerbates the hyperactivity. Diphenylhydantoin sodium was relatively ineffective against hyperactive behavior in two studies which included a total of 28 patients, but improvements in auditory perception were noted in children with learning disorders associated with abnormal electroencephalograms.

Dosage and Use of Methylphenidate in School Children

Initial dosage of methylphenidate is 0.25 mg/kg daily, given in two divided doses at breakfast and lunch; before meals in overweight and after meals in average or underweight children. The dose is doubled during each successive week of treatment up to an average optimum level of 2 mg/kg of body weight daily, provided untoward effects such as sleeplessness, increased nervousness and restlessness, depressive reactions and stomachache are not encountered.

The dosage is monitored on the basis of the responses indicated by reports of parents and school teachers and by neurological re-examination of the child. If a beneficial effect is apparent, continuation of treatment for periods of three to four months is warranted while the child is in school, a battery of neuropsychological tests being employed at intervals to measure responses quantitatively. The drug should be withdrawn during vacations and if school reports and tests show no appreciable change in behavior and learning. Drug treatment should not and need not be indefinite, and usually may be stopped after the age of 12.

Stimulant medications are used as adjuncts to remedial education and to facilitate learning, increasing the child's abilities to focus on meaningful stimuli and to organize his bodily movements more purpose-fully. Thirty years of clinical experience and several scientific studies have failed to reveal an association between the controlled, medical use of stimulants in the preadolescent child and later drug abuse.[5] ◄

References

1. Bradley: *Amer. J. Psychiat.* 94:577, 1937.
2. Millichap, J. G., et al: *Amer. J. Dis. Child.,* 116:235, 1968; *JAMA,* 206:1527, 1968.
3. Conners, C. K. and Eisenberg, L.: *Amer. J. Psychiat.* 120:458, 1963.
4. Millichap, J. G. and Fowler, G. W., *Ped. Clin. N. Amer.* 14:767, 1967.
5. Report of Conference, Office of Child Development, Department of Health, Education & Welfare, Washington, D.C., January 11, 1971.

LOW-COST GROUP INSURANCE
ANOTHER ISMS MEMBERSHIP PRIVILEGE

THE GROUP DISABILITY PLAN ● Provides up to $300.00 weekly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

BUSINESS OVERHEAD EXPENSE PLAN ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

THE FAMILY MAJOR MEDICAL EXPENSE PLAN ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Gross Daily Hospital Room and Board available. ● Subject to choice of deductible and 80% coinsurance.

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:
Administrators:
PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

Central Illinois Service Office: 849 Forest Lane—Petersburg, Ill. 62675 • phone 217-632-7220
Wayne J. Hubbert, District Manager

Angiosarcoma of the Liver

By Timothy G. Lee, M.D. and A. G. Lawrence, M.D./Oak Park

Hepatomegaly due to primary or metastatic tumors is not unusual, but when present, can be a diagnostic problem which, on occasion, may only be clarified by abdominal exploration. A rare primary cause, angiosarcoma,[1] should be considered under these circumstances and an extremely cautious approach to needle biopsy taken. An illustrative case of angiosarcoma of the liver forms the basis of this report.

Case Report

A 69-year-old man was admitted complaining of a dull ache in his right upper abdominal quadrant for two weeks which had become worse four days before admission. The pain was non-radiating, and associated with no other GI tract symptoms. The only abnormal physical findings were moderate pallor, marked hepatomegaly, mild tachycardia, and temperature of 100° F. Routine urinalysis was normal, Hgb-10.0 gm. WBC-10500 with a shift to the left, serum albumin-2.8 gm, alkaline phosphatase-42KA units, prothrombin time-14 sec (control-13 sec.) X-ray studies were as follows: upper GI series was essentially normal; colon showed a possible lesion in the cecum and evidence of hepatomegaly; and a liver scan revealed large defect in the right lobe of the liver with inhomogeneity of uptake throughout the remainder of the organ (Fig 1).

Because the weight of evidence seemed to favor the presence of a malignant tumor with liver metastasis, it was elected to do a needle biopsy of the liver in an attempt to establish the diagnosis without resorting to abdominal exploration. Accordingly, a percutaneous needle biopsy of the right lobe of the liver was performed. The frozen section showed fibroconnective tissue without evidence of malignancy. One hour following biopsy, the patient became restless and abruptly went into shock with respiratory arrest. Aggressive resuscitative measures were unsuccessful, including massive transfusion of whole blood and infusion of balance salt solution. Only temporary return of a feeble pulse occurred, and rather rapid abdominal distention was obvious.

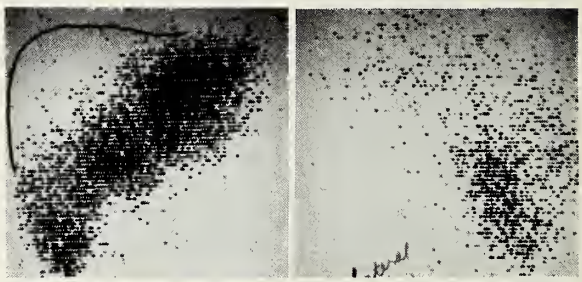


Figure 1: Liver Scan. (anterior and right lateral views.) A large defect in the right lobe of the liver with inhomogeneity of uptake throughout the remainder of the organ.

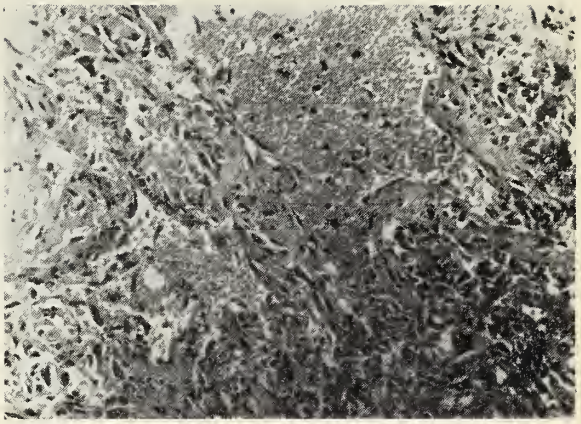
Pathology Findings

At autopsy, a large angiosarcoma of the liver measuring 10x15 cm was found (Fig 2, 3) complicated by massive intra-abdominal hemorrhage from the site of needle puncture. In addition, there were numerous satellite nodules throughout both lobes of the liver. The liver weighed 1840 grams. The surface was bosselated with multiple cystic spaces containing blood. This was found most extensively over the right lateral surface and the dome of the liver where an area measuring 18x15 cm was replaced by these cystic structures. The anterolateral surface showed a needle mark reflecting the site of the liver biopsy and there was leakage of blood from this site. The spaces were separated by fine glistening fibrous septa, one such area having been biopsied by the needle. In other areas, the hepatic parenchyma showed multiple solid, fleshy hemorrhagic nodules measuring 1.5 cm to 2 cm in diameter.

TIMOTHY G. LEE, M.D., formerly of the Department af Radialagy, West Suburbon Haspital, Oak Park, is now with the Department af Radiology at the University of Oregon, Partland, Ore.

A. G. LAWRENCE, M.D., is from the Department of Surgery at West Suburban Haspital, Oak Park; Associate Clinical Professar af Surgery at the University of Illinois Schaol of Medicine and Attending Surgeon at Cook County Haspital.





Figures 2 & 3: A large angiosarcoma of the liver with satellite nodules and multiple cystic changes. The appearance of the gross pathology and the liver scan can be superimposed. Vascular spaces and masses of endothelial cells in various degrees of differentiation are seen microscopically.

The entire liver was involved by this pathologic process.

Discussion

Angiosarcoma[2] is a very rare malignant tumor of vascular origin. It occurs at all ages with no sex predominance and may be found anywhere in the body, most often in the skin, liver, spleen, lungs, and bones. The tumor is usually quite large flashy mass, with frequent central necrosis and hemorrhage with poorly defined margins. Microscopically, it is characterized by vascular spaces and masses of endothelial cells in various degrees of differentiation. This tumor is locally invasive and dissemination is usually hematogenous, although lymphogenous spread may occur. Prognosis is poor, most patients surviving less than one year.

Percutaneous needle biopsy of the liver is a relatively safe and accurate procedure when used selectively, but there are definite contraindications, risks and complications.[3] Less than one death in 1000 biopsies occurs, although the incidence may be higher since not all fatalities are reported. Hemorrhage is the most common cause of death. Since liver scan is frequently used as a guide to biopsy when a space-occupying lesion is suspected and demonstrated, awareness of angiosarcoma or other vascular tumors is important, as illustrated by this case. This, unfortunately, is not frequently stressed although in differential diagnosis of focal defects in the liver scan, vascular tumors are included in practically every discussion.[4,5] While there are no diagnostic features in differentiating an angiosarcoma from other tumors of the liver, a single large defect seen in the liver scan should make one suspicious of this tumor,[2] in addition to the other possibilities. Under these circumstances, further study by selective celiac angiography should be done before needle biopsy. Such an approach would have avoided the sudden death in this patient.

Summary

The diagnosis of a vascular tumor of the liver must be considered in the differential diagnosis when a defect is seen on the liver scan.

Precautions in diagnostic procedure are stressed and the value of selective celiac angiography is emphasized. ◄

References

1. Ackerman, L. V., delRegato, J. A.: CANCER. p. 1190, C. V. Mosby Co., 3rd Ed., 1962.
2. Robbins, S. L.: PATHOLOGY, pp. 614-615, 3rd Ed., 1968.
3. Wilber, R. D., et al: "Percutaneous Liver Biopsy." *JAMA*, 202:147-9, 2 Oct 67.
4. Siber, F. J. Au198 and the Diagnosis of Hepatic Tumor." *Rad Cl N Am.*, Vol IV No 3, p 584, Dec 1966.
5. Wagner, H. W.: PRINCIPLES OF NUCLEAR MEDICINE, p. 614, W. B. Saunders Co., 1968.

"Patient can come... and be deaf, dumb and blind... not feeling or indicating anything... and we would locate the cause of what ever he had, adjust him, and send him home well."



"Snap, Crackle and Pop!"

This article has been prepared to give the membership insight into just exactly what chiropractic is and does—and how it exists. It is imperative that the membership be knowledgeable about this and inform our patients of the verities. It is significant to note the wide number of organizations who have spoken out against chiropractic, and it still continues. We must be ever-vigilant, ever-active to continue to protect the health and well-being of the public and guarantee to all citizens a standard of health care of the highest possible level.

William M. Lees, M.D.
Chairman, ISMS Board of Trustees

Chiropractic (the word is used both as an adjective and a noun) was invented by Daniel David Palmer, an Iowa grocer turned cultist. At first he looked into osteopathy, which was in its infancy in the mid-1800's, then into phrenology and spiritualism. In 1886, he set up a "magnetic healing studio" in an attempt to find what he felt was Nature's Great Secret—*the* cause of human disease.

The "art" of chiropractic was born in 1895, when Palmer encountered a janitor named Harvey Lillard who had been deaf for 17 years. Learning that Lillard had become deaf when he was exerting himself in a cramped, stooping position . . . and felt something give way in his back, Palmer examined him and *found* a "subluxated" (misaligned) vertebra in his spine. He convinced Lillard to allow him to apply firm pressure to the vertebra with his hands. As Palmer tells the story in his book entitled TEXT-BOOK OF THE SCIENCE, ART AND PHILOSOPHY OF CHIROPRACTIC FOUNDED ON TONE, the vertebra moved back into place "and soon the man could hear as before."

Palmer confided his discovery to a friend, Reverend Samuel Weed, who suggested that the new marvel be called "chiropractic," from the Greek *chiero* ("by hand") and *praktikos* ("to do"). Soon thereafter, the Palmer School of Chiropractic opened its doors in Davenport, Ia.

Current Definitions

The International Chiropractors Association assumes that "Disease or abnormal function is caused by interference with nerve transmission and expressions due to pressure, strain, or tension upon the spinal nerves, as a result of bony segments of the vertebral column deviating from their normal juxtaposition."[2]

Its opposite counterpart, the American Chiropractic Association, states that "Chiropractic practice is the specific adjustment and manipulation of the articulations and adjacent tissues of the body, particularly of the spinal column, for the correction of nerve interference."[3]

Both groups indicate that *all* disease is caused by "luxated bones," mostly in the spinal column. "By their displacement and pressure they elongate the pathway of the nerve . . . displacing it from a direct line. This pressure creates tension, increased vibration, and consequently an increased amount of heat. Heat alters tissue; altered tissue modifies the transmission of impluses; modified impulses cause functions to be performed abnormally."[4]

Treatment consists of "adjustments" of the spine—twisting, pulling, stretching, massage, etc. —to eliminate a "subluxation," or accomplish a "spinal adjustment."

Division in the Ranks

Chiropractic has divided into two distinct schools of thought: the straights and the mixers. The straights (International Chiropractic Association) believe that "adjustment" alone deals with and eliminates disease. The mixers (American Chiropractic Association) believe that additional physical and nutritional treatment also is necessary.

Both schools of thought lack scientific validity and indicate that "spinal adjustment" is *the* treatment of any and all disease. There is no need for diagnosis, and regular adjustments will prevent disease, according to most chiropractors.

According to the late B.J. Palmer, son of D. D. Palmer, "the chiropractor need not diagnose, and diagnosis is unimportant to him." One statement is especially significant: "The chiropractor pays little, if any, attention to symptoms or pathologies. Patient can come . . . and be deaf, dumb, and blind—not telling or indicating anything—and we would locate the cause of whatever he had; adjust him, and send him home well."[5]

Thus, it is significant that claims are being made by chiropractors to be able to "cure," or treat, or prevent such things as diabetes, acne, epilepsy, ulcers, sore throat, mental illness and polio, among some 95 conditions treated by them. It also decries such things as immunization, claiming that polio, smallpox, diphtheria, and all communicable diseases, even cholera, typhoid and malaria, would never be transmitted to a person with a completely aligned vertebral column. Added to gadgets and gimcracks, this constitutes a perversion, a bilking of the public.

Who Goes to Chiropractors?

The answer seems to be almost anyone. Among notables who were chiropractic patients were John D. Rockefeller, Sr., Presidents Coolidge and Eisenhower, Fred Allen, Clara Bow, Eddie Cantor, Enrico Caruso, Clarence Darrow, Mahatma Gandhi, and Madame Chiang Kai-shek.

Many persons consult chiropractors since they have been allowed to advertise for patients in some states, and often circulate ads which promise cures of everything from obesity to hemorrhoids. A chart from the Parker Chiropractic Research Foundation's Textbook of Office Procedure and Practice Building for the Chiropractic Profession, (pages 151-52) indicates the average number of "adjustments" given by chiropractors for various disorders. The number ranges from a low of 28.2 for acne to 84.1 for jaundice. Many of these disorders probably are self-remitting within the time frame of, say, "60 adjustments."

One writer on the subject has estimated that as of 1969, chiropractors were treating about three million persons a year, and that the annual income of all such practitioners is about $300 million. This works out to an average per-chiropractor income of $15,000 a year in 1969.

X-Rays

The usual chiropractic visit includes an X-ray known in the trade as a "spinography." Most of the X-rays are 14-by-36 inch chest shots, which are mounted on a screen and sectioned off into two-inch squares drawn on the negative with radio-opaque ink, to help visualize disturbances in the longitudinal alignment of the vertebral column. Chiropractors claim these X-rays locate problem areas, called "subluxations" (apparently meaning incomplete dislocation) in the spinal column. Taking of these X-rays exposes patients to large, unnecessary doses of radiation from the

neck to the genital area.

The uselessness of these X-rays has been pointed out by an independent study conducted by the National Association of Letter Carriers. A review of 300 sets of X-ray films used by chiropractors showed that over half were totally unfit for any diagnostic purpose. In another instance, 20 sets of film submitted with a chiropractic diagnosis of subluxation were reviewed by a team of chiropractic "experts" who were unable to find the subluxation for which benefits were claimed. As a result, the National Association of Letter Carriers deleted their insurance coverage of chiropractic services.

One might note that medical radiology technique utilizes very small films, zeroing in small areas of the body, with very refined diagnosis, thus exposing the patient to a minimum of radiation. Chiropractic "examinations" average two exposures. Assuming a dose of one rad per exposure on only California chiropractic patients, this procedure would account for at least 500,000 man-rads per year. This is 1000 times more than the radiation exposure of the entire 220,000,000 U.S. population from all currently operating nuclear power plants. Much leukemia, cancer and genetic defect possibly has been caused by this fraud.

Before submitting to X-ray diagnosis by a chiropractor, a patient should consider the statement made in 1971 by a vice-president of the oldest established school of chiropractic ". . . chiropractors do not make the claim to be able to read a specific subluxation from an X-ray film."[6]

Snap, Crackle, and Pop!

Chiropractic "adjustment" is frought with hazards. There are well-documented cases of serious disorders of the spine "treated" by chiropractors, with resultant bruising and further injury.[7] Grave, permanent injury, including paralysis, could occur when someone has a slipped disc "adjusted," since instead of bed rest and healing the condition could be worsened due to the "cracking" when the "adjustment" is accomplished. Snapping the neck, twisting the spine, and popping joints, as accomplished by chiropractors, may lead to serious brain damage, paralysis, loss of control of body functions, or even death. Rather than alleviating an illness, often the condition is made worse, and proper medical treatment has been delayed, which in itself may lead to an unfortunate outcome of illness.

Recent scientific study, in addition, has demonstrated the impossibility of nerve interference by a "sub-luxation."[8]

The Chiropractor's Doctor

While chiropractors claim that the root cause of *all* human illness is misalignment of the vertebrae in the spine, when a chiropractor or his family develops some malady, according to various documented cases, the chiropractor sees a medical doctor.[9] Apparently chiropractic cannot cure the ills of chiropractors. The founder of the only Chiropractic Hospital in the United States, in Denver—Leo Spears, a diabetic—was a regular patient of a medical physician, since he was on insulin therapy.[10]

Education and Licensure

Chiropractic schools offer a four-year course leading to a Doctor of Chiropractic degree. The first two years mainly cover basic science subjects, with some outpatient clinical exposure at the end of the second year. The last two years deal almost totally with chiropractic and outpatient care.

Also, one must bear in mind that as recently as March, 1974, none of the 10 colleges of chiropractic was accredited, recognized or listed by either of the two national education bodies that recognize agencies that accredit institutions of higher education in the U.S. The Office of Education, HEW, and the National Commission on Accrediting have consistently refused to recognize these institutions. In Illinois, the only national accreditation of the National College is by the American Chiropractic Association.

Chiropractic philosophy does not contain emphasis on research. In addition, while chiropractic claims to include more instruction hours than medical schools, the courses usually are didactic lectures with emphasis on "selling" a service.

The Department of Health, Education and Welfare, in a report entitled *"Independent Practitioners Under Medicare,"* (1968) cites the following shortcomings in chiropractic education:

(1) Lack of inpatient hospital training;

(2) Lack of adequately-qualified faculty;

(3) Extremely low admission standards for students;

(4) Lack of a nationally-recognized accreditation body;

(5) Such dissention within the profession that two separate accreditation programs must be maintained.

They conclude: "These shortcomings raise serious doubts as to the qualification of chiropractors generally to make an adequate diagnosis and effectively treat patients."

The fact that many states currently license chiropractors implies to the public that there has been complete "medical" education. However, in light of the training given, non-accredited schools, and lack of scientific knowledge, an entirely different testing procedure is followed in licensing chiropractors from that required of medical or osteopathic physicians. In Illinois, the license issued is *limited* to the treatment of human illness without the use of drugs or surgery. While according to law, testing of chiropractors should be the same as for physicians, with certain exceptions, chiropractors never have taken the same examination as physicians.[10]

Lobby Efforts

The chiropractic lobby effort is significant. As Ralph Lee Smith puts it:

> "From its infancy, chiropractic looked to politics and licensing, not as a way of working with science, but as protection against science. . . . In all this intensive and amazingly skillful political campaigning, state and county chiropractic groups receive expert help and strong back-up from the two national chiropractic associations. Much of the program of these two groups is oriented toward political action, and the activities are guided by political veterans who have the experience and the contacts. The executive director of the American Chiropractic Association is Norman A. Erbe, former governor of Iowa. . . . If decisive measures are not taken, there is every reason to believe that these new efforts to make chiropractic a central feature of health care in the United States will succeed."

Probably the first victory for chiropractic was won early in this century, when by 1925 the lobby succeeded in getting licensure laws through 32 of the nation's 48 rurally-dominated state legislatures. In so doing, these states lent respectability to the chiropractors; citizens understandably confused such action as endorsing a valid healing practice. Legislators who were aware of the conflict between chiropractic and science felt a possible way out would be to vote for the licensure law which would at least give the state power to control and limit chiropractic practice. "The truth, of course, is that the limitations placed on the scope of their practice by the state laws are of little moment to chiropractors compared to the granting of the state's medical doctor's license."[7]

The Appeal

Modern medicine is making great strides in diagnosis and treatment of disease. Many people are alive today because of "break-throughs" of the past several decades.

Despite these advances, many unknown factors remain. In many instances the appeal of chiropractic treatment is made on these unknown factors.

The medical doctor often must tell a patient that treatment may take a long time; the chiropractor might say that his "relief" will be speedy. The medical doctor may have to tell the patient that the disease is complex; the chiropractor continues to say that it is simple. Occasionally the physician must indicate incurability—the chiropractor states he will give permanent or lasting treatment. The medical doctor often has to tell his patient that treatment will be expensive; the chiropractor's treatment, by comparison, may cost less.

What is To Be Done

Basic to activity is the individual physician. Physicians must become fully knowledgeable, must educate their patients, and must help ISMS to generate activities to eliminate chiropractic. Following are some specifics:

Obviously, there should be elimination of chiropractic. This may be unrealistic at this time, due to an unusually strong lobbying voice in the legislature as well as the extremely effective public relations program of chiropractic organizations.

In order to effectively meet specific activities by individual chiropractors, it is necessary, as a first step, that each and every member of ISMS be alert to what chiropractors are doing, especially those activities which constitute the illegal practice of medicine. Some ISMS members have supplied documentation (preserving confidentiality) of cases treated by chiropractors where there was an unfortunate outcome, when medical treatment probably would have precluded this. These will be useful in a "white paper" on what chiropractors do and how they harm the public. More reports are needed.

Chiropractic advertising also is illegal. Each instance, with documentation, should be reported promptly to ISMS so an official complaint may be lodged with the Department of Registration and Education. In addition, some media have carried features on what a specific chiropractor may be doing. If, for example, he is using acupuncture, this also should be referred to ISMS immediately, as this violates regulations and warrants an official complaint.

Successful pressure on the Department of Registration and Education to require the same examination of chiropractors as of doctors of medicine, as stipulated in the statutes, would quickly cut off the flow of new chiropractors.

It also is recommended that physicians not "debate" with chiropractic practitioners, since this lends status and credence to them and implies a certain equality. This is part of the pub-

lic relations scheme of chiropractic—to get public exposure in the press, on the airways, before school groups, or wherever possible. This would apply as well to rebuttals of items appearing in the media.

Consideration must be given to further delimit and define the limited scope of chiropractic practitioners, both in the Medical Practice Act and by regulation. To this end, the ISMS Committee on Quackery will explore various alternatives.

It also should be required that chiropractors not be allowed the use of X-ray, since the deleterious effect on the public health must be eliminated.

What Others Say

Recently many independent organizations have studied the problem and have arrived at similar, basic conclusions.

Wisconsin Chiropractic Study Committee of the Governor's Health Planning and Policy Task Force

(October, 1972) on which there was no medical doctor: ". . . it is anachronistic to permit an academically unrecognized, scientifically unproven and medically uncontrolled method of health care to infringe . . . and impair optimum quality care."

Health Insurance Benefits Advisory Council

An official group of advisors, under statute, to the Federal Government: "The council is unanimously of the view that such services have no medical value and 'might only result in harm to Medicare beneficiaries because of delay or avoidance of seeking proper medical care.' "

Harriet Van Horne

In her column of December 23, 1972: "chiropractors . . . may be kindhearted, charming men; they may have strong hands and beautiful massage 'table manners,' but medically speaking . . . they are a menace."

Richard Lyons

In the *New York Times,* Nov. 19, 1972: "If the Federal Court decision affirmed by the U.S. Supreme Court requires definitive, scientific validity for the hypothesis of chiropractic, or that the proof of subluxation be shown to the satisfaction of qualified roentgenologists, then chiropractic must soon disappear from the face of the earth."

Maine Legislative Research Committee Report on Chiropractic Services (January, 1973)

"The committee unanimously opposes recommending any change which will operate to broaden the scope of chiropractic practice in the State of Maine beyond the limits of existing law."

AFL-CIO Executive Council Statement on Chiropractic Services (February 26, 1973)

"We do not believe that chiropractors should perform the functions of a physician or serve as the point of entry into the health system. Therefore, chiropractic services covered in public programs should be used only after it is determined that chiropractic services may be helpful in treating a patient's condition."

American College of Radiology "Position Statement" (August, 1973)

"Except as limited to malalignment or dislocation of spinal vertebrae, a routine radiographic examination of the spine would not be definitive of a subluxation, should one be claimed. Much more sophisticated examinations of types not ordinarily attempted by chiropractors, would be required to demonstrate somatic or neurological problems.

". . . in the course of various public health obligations, workmen's compensation programs, and other non-clinical situations, some radiologists have occasion to see films obtained and interpreted by chiropractors. There are two major criticisms of the chiropractic films:

1. The radiographic technique is frequently unacceptable in terms of film quality, proper collimation, positioning, development, and handling. Such flaws often make the film of no diagnostic value to anyone.
2. Where films are of diagnostic quality, the chiropractor's report of his interpretation often omits mention of significant somatic pathology which is either missed by the chiropractor or else does not relate to the purported subluxation which is supposedly demonstrated.

"The implementation of a requirement which would at least seem to encourage chiropractors to expose Medicare beneficiaries to even more X-ray procedures than is currently the custom is potentially distressing to anyone concerned with safe and efficacious use of X-rays in medicine."

"American Scientist" Volume 61, November, 1973 Edmund S. Crelin, M.D., Yale University Researcher

"This experimental study demonstrates conclusively that the subluxation of a vertebrae as defined by chiropractic —the exertion of pressure on a spinal nerve by interfering with the planned expression of Innate Intelligence produces pathology—does not occur. This is what should be expected when one recognizes that the vertebral column support (s) the body and protect (s) the central nervous system. . . . the vertebral column of mammals allow (s) an overall range of motion so that individuals may function well for survival within their environment. At the same time, the selective process has favored vertebral columns that have spacious intervertebral foramina in combination with the barest minimum of displacement between adjacent vertebrae—two factors that preclude impingement upon the spinal nerves as they pass through the foramina."

The Health Insurance Association of America

The HIA, which collectively writes 90% of the health insurance in the United States, has opposed any legislation which would mandate chiropractic or naturopath coverage.

American Rheumatism Association Section of the Arthritis Foundation Statement on Chiropractic (1971)

"There is no valid evidence that chiropractic treatment of rheumatic disease is effective. When patients receive chiropractic manipulation and thereby delay the institution of sound medical treatment, they may increase the probability of later crippling and disability."

"The chiropractors' claims to knowledge of the cause of arthritis are not supported by any scientific method of investigation nor by any known, recognized medical authority, and their concept of disease is constricted in scope and theoretically unsound."

"Chiropractors lack the special knowledge, training and skills needed to diagnose and treat arthritis and related diseases. The avowed general attitude of chiropractors, that drugs and medicine are not dependable for the treatment of disease and that surgery is a mutilation of the body, is contrary to accepted scientific evidence."

U.S. Department of Health, Education & Welfare

The U.S. Department of HEW submitted to Congress findings of an independent, unbiased study of chiropractic ordered by Congress under the title of "Independent Practitioners Under Medicare" with a letter of transmittal dated December 28, 1968, and signed by Wilbur J. Cohen, then Secretary of HEW. In regard to chiropractic, the Conclusions and Recommendations of the HEW report were:

Conclusions

1. There is a body of basic scientific knowledge related to health, disease and health care. Chiropractic practitioners ignore or take exception to much of this knowledge despite the fact that they have not undertaken adequate scientific research.
2. There is no valid evidence that subluxation, if it exists, is a significant factor in disease processes. Therefore, the broad application to health care of a diagnostic procedure such as spinal analysis and a treatment procedure such as spinal adjustment is not justified.
3. The inadequacies of chiropractic education, coupled with a theory that de-emphasizes proven causative factors in disease processes, proven methods of treatment, and differential diagnosis, make it unlikely that a chiropractor can make an adequate diagnosis and know the appropriate treatment, and subsequently provide the indicated treatment or refer the patient. Lack of these capabilities in independent practitioners is undesirable because: appropriate treatment could be delayed or prevented entirely; appropriate treatment might be interrupted or stopped completely; the treatment offered could be contraindicated; all treatments have some risk involved with their administration, and inappropriate treatment exposes the patient to this risk unnecessarily.
4. Manipulation (including chiropractic manipulation) may be a valuable technique for relief of pain due to loss of mobility of joints. Research in this area is inadequate; therefore, it is suggested that research that is based upon the scientific method be undertaken with respect to manipulation.

Recommendation

Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment. Therefore, it is recommended that chiropractic service not be covered in the Medicare program.

Task Force on Medicaid and Related Programs

In its report to the U.S. Secretary of Health, Education and Welfare, dated June 30, 1970, the Task Force on Medicaid and Related Programs concluded that payment for chiropractic and naturopathic services "is not an effective use of Federal Medicaid funds." The report recommended:

"A legislative amendment should be enacted denying Federal financial participation in Medicaid payments to chiropractors and naturopaths."

National Advisory Commission on Health Manpower

In its 1967 report to the President, the National Advisory Commission on Health Manpower states, "Although chiropractic is not the only existing cult, it is the only one which still constitutes a significant hazard to the public."

In discussing state licensure of chiropractors, the Commission also says: "Ideally . . . the statutes should be repealed to remove the cult's shield of legitimacy," and adds: ". . . It should be recognized that no matter how high they are set, no matter how strictly they are enforced, licensure standards cannot redeem the scientific invalidity of chiropractic."

In its summary and conclusions, the Commission states: "Attempts to control unscientific schools of practice or cultism by licensure cannot give unscientific practices a scientific basis but can endanger the public by giving unscientific schools, such as chiropractic, protection through the sanction of law."

American Public Health Association

The following resolution was approved by the Governing Council, American Public Health Association, November 13, 1969:

"It appears that the practice of chiropractic and naturopathy constitutes a hazard to the health and safety of our citizens. The American Public Health Association therefore urges:

"1. That Congress amend Title XIX of the Social Security Act to specify that Federal funds not be used to match State Medicaid expenditures for chiropractic or naturopathic services.

"2. That Congress not amend XVIII of the Social Security Act to permit coverage of chiropractic or naturopathic services in the Medicare program.

"3. That State legislatures and health agencies not include chiropractors and naturopaths under State health programs.

"4. That States reevaluate their existing licensure programs for chiropractors and naturopaths to determine whether such licenses should be further restricted or abolished, and that existing restrictions be more rigorously policed.

"5. That professional and consumer groups undertake appropriate consumer education on the hazards of unscientific health care, including chiropractic and naturopathy."

AFL-CIO

Excerpt from Fact Sheet" submitted by AFL-CIO in connection with testimony by Andrew J. Biemiller, Director, AFL-CIO Legislative Department, before U.S. Senate Finance Committee, September 15, 1970:

"Care of patients should only be entrusted to those who have a sound scientific knowledge of disease and whose experience and competence render them capable of diagnosing and treating patients by utilizing all the resources of modern medicine. Since neither chiropractic theory nor the quality of chiropractic education equip chiropractors to do this, the AFL-CIO opposes coverage of chiropractic services in the Medicare program."

Consumer Federation of America

The Consumer Federation of America, representing 184 local, state and national consumer-oriented organizations with millions of members throughout the nation, adopted the following resolution at its Annual meeting on August 29, 1970:

WHEREAS, CFA is concerned that studies of chiropractics have not produced evidence of the scientific validity of chiropractic theory and practices, and

WHEREAS, CFA is gravely concerned that medicare coverage of chiropractic services would needlessly expose beneficiaries to potential health hazards—particularly the harm which would result when beneficiaries treated by such practitioners delay or avoid seeking proper medical care, and

WHEREAS, chiropractors are not trained to diagnose possible malignancies, diabetes, acute heart conditions or similar systemic diseases which frequently underly the symptomatic complaints of their patients, and

WHEREAS, the aged and needy are most vulnerable to patient management techniques but frequently less capable of judging the efficacy of the treatment they receive, and

WHEREAS, in addition to increasing the health hazards to beneficiaries, the inclusion of chiropractic services

would add substantially to the cost of the Medicare program.
BE IT RESOLVED, that CFA urges the Senate Finance Committee to reject the inclusion of chiropractic services under the Medicare, Medicaid, and all other federally supported health programs at this time.

National Council of Senior Citizens

Excerpt from the *Senior Citizens News*, January, 1969, official publication of the National Council of Senior Citizens:
"Chiropractic treatment, designed to eliminate causes that do not exist while denying the existence of the real causes, is at best worthless—and at worst mortally dangerous."

Association of American Medical Colleges

Excerpt from letter of January 26, 1970, from the Association of American Medical Colleges to the Ways and Means Committee of the U.S. House of Representatives:
". . . The overwhelming evidence of a lack of scientific base, as well as other educational shortcomings, in the training of chiropractitioners strongly suggests that the inclusion of a provision which gives these individuals an opportunity to bill and collect fees under Part B of the Medicare program would not be in the best interests of the beneficiaries of the program. Furthermore, we believe that it is imprative that the program's beneficiaries be assured that the care to which they are entitled conforms to the highest standards. It is our conclusion that this would not be true if chiropractic services were provided with an opportunity to participate in the supplementary medical insurance plan under the medicare program."

American Cancer Society, Inc.

The Executive Committee of the American Cancer Society approved the following official statement in July, 1967:
"Chiropractic is not based on a sound scientific medical approach to cancer and has no place in the diagnosis or treatment of cancer. Because early diagnosis and proper treatment of cancer are vital in the saving of lives and the diminution of suffering from cancer, the use of chiropractic in the diagnosis or treatment of persons afflicted with cancer represents a health hazard."

National Association for Retarded Children

The Board of Directors of the National Association for Retarded Children, upon the recommendation of the NARC Public Health Services Committee, unanimously endorsed the following statement in 1968:
"Because of the increased national interest in helping the mentally retarded, it is vitally important that the NARC goes on record as stating that the Association knows of no established scientific evidence that supports the value of any current practices of chiropractors in diagnostic, therapeutic or education activities in mental retardation."

American College of Sports Medicine

A statement adopted by the American College of Sports Medicine in 1968 emphasizes:
"The American College of Sports Medicine does not recognize practitioners of chiropractic, naprapathy, and naturopathy as appropriate for membership in the College because the College considers the principles underlying their alleged healing practices are not founded on scientific grounds." ◄

References

1. Zeuch, Lucius H.: History of Medical Practice in Illinois, Volume I, 1800-1850, Illinois State Medical Society, Chicago, 1927.
2. "International Chiropractors Review" International Chiropractors Association, March, 1964, p. 2.
3. *Journal* American Chiropractic Association, Nov., 1963, p. 13.
4. D. D. Palmer: Testbook of the Science, Art and Philosophy of Chiropractic, Founded on Tone, Portland Printing House Company, Portland, OR, 1966, p. 18.
5. B. J. Palmer: *Bigness of the Fellow Within,* p. 56.
6. Letter of H. Ronald Frogley, D.C., Ph.C., Vice-President, Palmer College of Chiropractic, Davenport, Iowa, July 15, 1971.
7. Smith, Ralph Lee: At Your Own Risk—The Case against Chiropractic. Pocket Books, New York, NY, 1970.
8. *American Scientist* Volume 61, Nov. 1973, pp. 572-580.
9. Smith, p. 95.
10. Smith, Chapter 9.
11. Communication from Illinois Department of Registration and Education, Medical Examining Committee, 1973.

▲ **Milwaukee Psychiatric Hospital** { Intensive, dynamic psychotherapy for adults and adolescents, individually planned activity therapy.

▲ **Milwaukee Sanitarium** { Geriatric program of superior care . . . custodial services for persons with chronic emotional illness.

▲ **Dewey Center** { Acute detoxification and inpatient treatment for alcoholic dependency, daily schedules, broad supportive services.

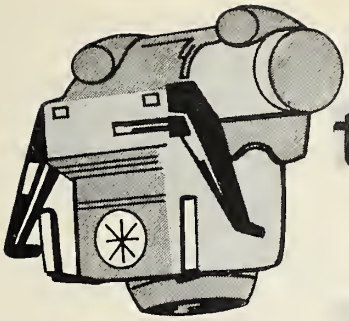
Units of: MILWAUKEE SANITARIUM FOUNDATION
1220 DEWEY AVENUE • WAUWATOSA, WIS. 53213 • PHONE (414) 258-2600

Affiliated with Medical College of Wisconsin

Accredited by the Joint Commission on Accreditation of Hospitals

Non-Profit Non-Sectarian Est. 1884 Participating Member Blue Cross-Blue Shield

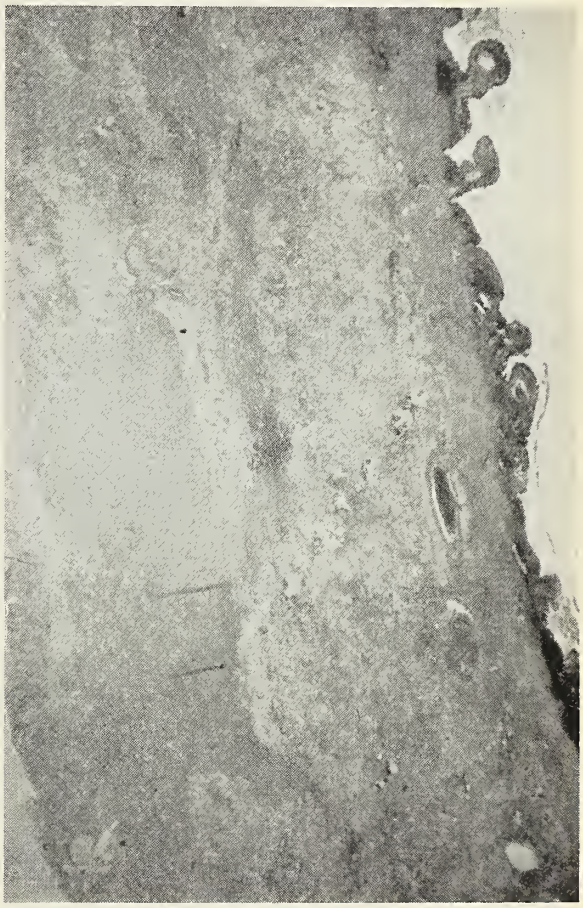




the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine





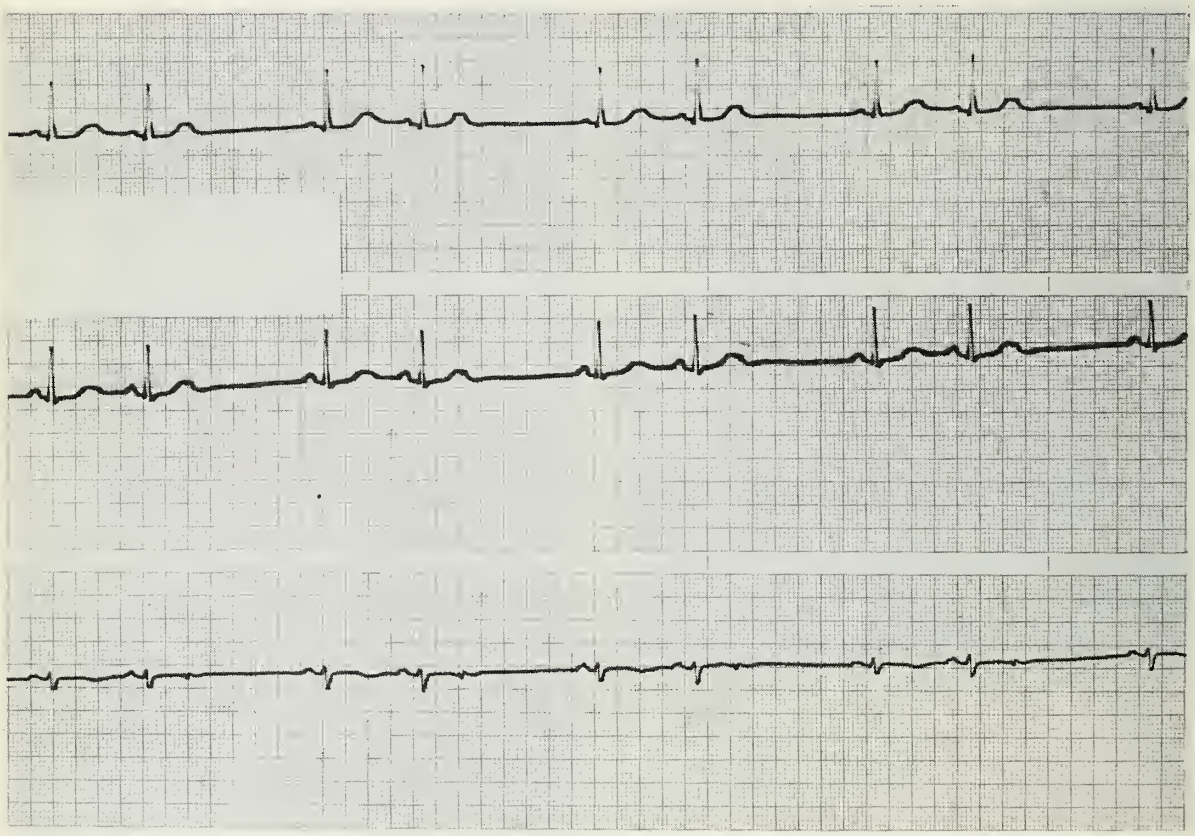
A 33-year-old female entered the hospital with acute right upper quadrant pain, temperature of 102°, and evidence of a mild degree of jaundice. Physical examination revealed tenderness in the right upper quadrant. An intravenous cholangiogram was considered but it was felt that the degree of jaundice was such that the procedure would be non-diagnostic.

What's your diagnosis?

(Answers on page 361)

ekg of the month

John R. Tobin, M.D., M.S., Rimgaudas, Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., James V. Talano, M.D., Sarah Johnson, M.D. and Rolf M. Gunnar, M.D., M.S./Section of Cardiology, Loyola University Stritch School of Medicine



A 62-year-old lady presented with dizziness on and off for the past two months. She described these sensations as feeling as if she would faint. Her blood pressure was 110/70, and her pulse rate was 40 beats per minute. After an ECG was taken, the patient was admitted to the hospital and started on quinidine 400 mg four times a day. The patient felt somewhat better two days later when the ECG shown here was taken.

Questions:

1. **The ECG shows:**
 - A. A 3:2 sino-atrial block.
 - B. A pattern of bigeminy.
 - C. Non-conducted premature atrial beats.
 - D. An atrioventricular Wenckebach pattern.
 - E. None of the above.
2. **Which of the following statements are true?**
 - A. Premature atrial beats can be seen in apparently healthy individuals as well as those with heart disease.
 - B. If premature atrial beats occur frequently, they may lead to atrial arrhythmias.
 - C. Non-conducted premature atrial beats can be seen in patients with digitalis intoxication.
 - D. The pause following a premature atrial beat is usually non-compensatory.
 - E. All of the above.

(Answers on page 361)

Pediatric Perplexities
Ruth Andrea Seeler, M.D., Editor

Simple Fluoroscopic Studies For Upper Airway Problems

By Vivian J. Harris, M.D., Director, Department of Pediatric Radiology; and Wrophas Meeks, M.D., Fellow, Pediatric Radiology

Cook County Hospital and the Hektoen Institute of Medical Research/Chicago

"Pediatric Perplexities" is a series of encounterable, but slightly uncommon, pediatric disorders which require prompt diagnosis and specific management for a good outcome. The editor welcomes suggestions for types of cases that the readers would like to have presented and discussed.

Upper airway obstruction, a relatively common problem in infants and young children, ranges in spectrum from mild to potentially lethal. Roentgenographic examination is the easiest and most reliable method to differentiate croup from epiglottitis, masses from stenosis or foreign bodies.[1-4]

However, the roentgenographic examination is dependable only if films are taken in a true lateral position! Normal variations are numerous and masses may be simulated by various superimposing structures (inferior turbinates, ear lobe, lingual tonsil) or by structure displacement secondary to expiration phase or swallowing. The normal posterior pharyngeal wall in a child under one year of age is unusually mobile and during expiration will buckle forward suggesting a retropharyngeal mass. If swallowing occurs at the moment the film is taken most of the air in the upper pharynx and nasopharynx is displaced and may then suggest a large adenoidal mass.[5-7]

The endolateral view of the neck is useful for excluding obstruction and masses of the upper airway in young children. The technique requires holding the child erect in the lateral position, with the arms held behind the body, neck in neutral position and chin slightly flexed. The diaphragmatic leaflets are included in the film to check phase of respiration. There are many problems involved in obtaining excellent endolateral views. In crying, squirming children it is difficult to maintain an exact position; two people are frequently required to hold the child.

In an effort to solve the many problems involving interpretation of lateral views of the upper airway we present a simple fluoroscopic technique. Two to eight fluoroscopic spot films of the upper airway are taken with the child lying in true lateral supine position. The spine

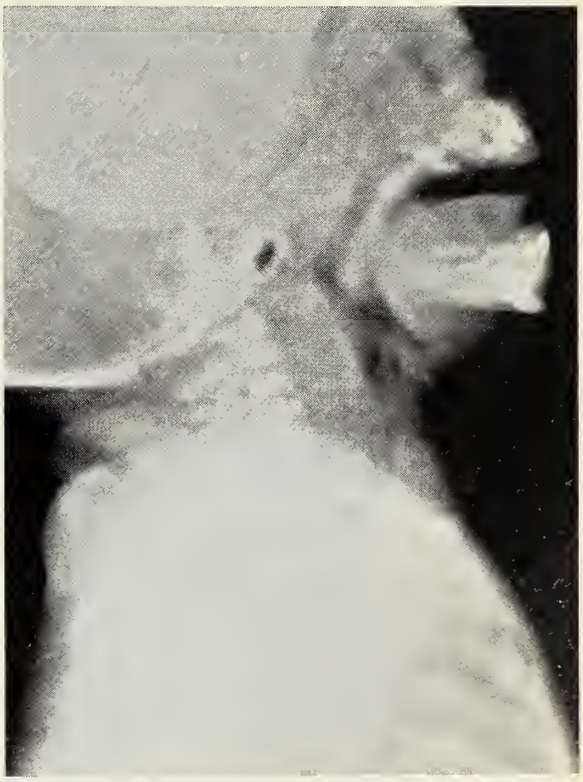


Fig. 1. Endolateral view of the neck shows good air filling of hypopharynx, larynx and trachea. Air column is anteriorly displaced in relation to the cervical vertebrae.

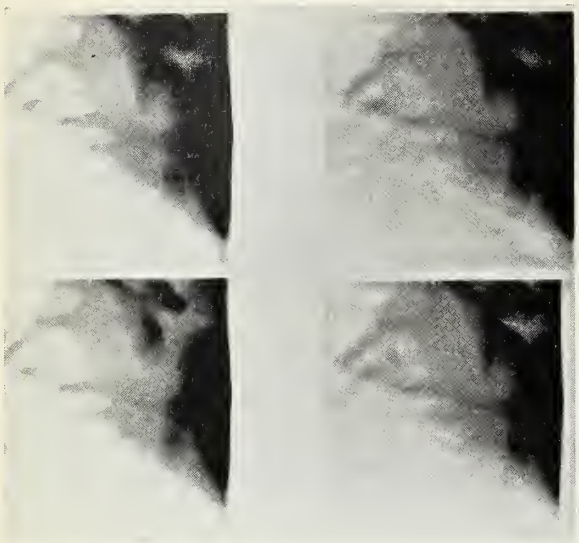


Fig. 2. Four fluoroscopic spot films demonstrate that the anterior displacement is persistent and therefore cannot be ascribed to mobility of pharynx in this age group.

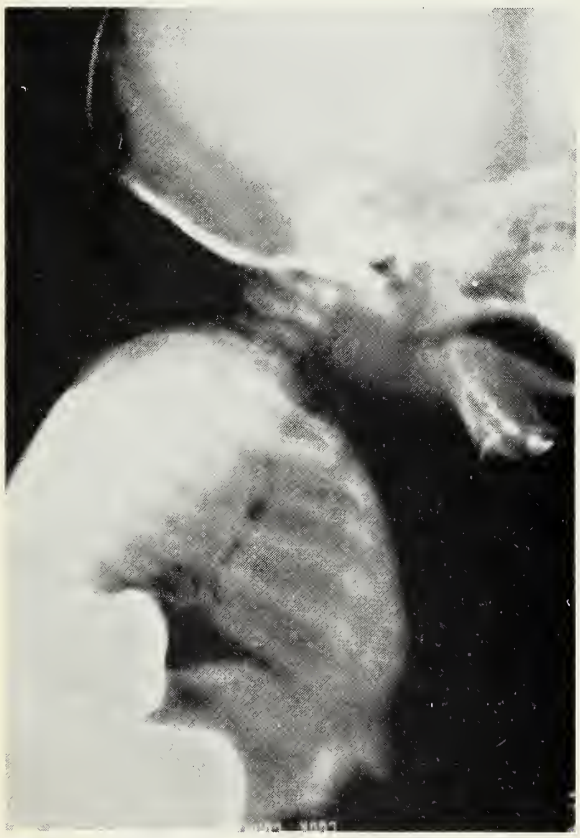


Fig. 3. Endolateral view of the neck shows poor filling of hypopharynx and larynx presumably due to the patient swallowing at the moment the film is exposed.

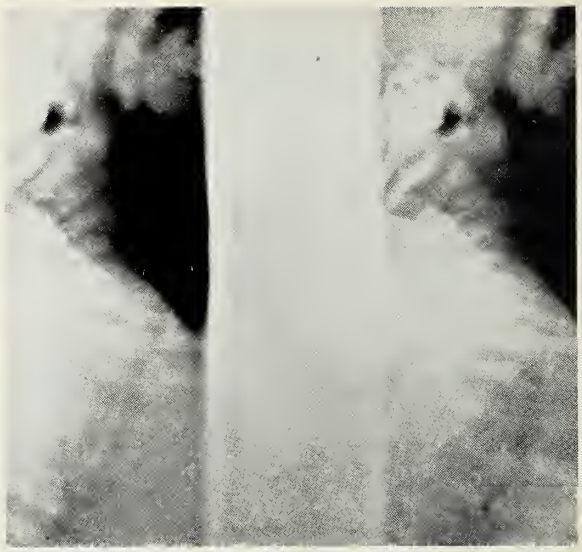


Fig. 4. Spot fluoroscopic films show good air filling with no mass visible. On the right the pharynx and upper trachea show normal expiratory narrowing.

is in neutral position and chin is held between flexion and extension. A series of randomly taken spot films generally results in different phases of respiration being represented. The following are examples of the usefulness of this technique.

Case Reports

Case #1

A child is presented with enlarged neck nodes and an apparent retropharyngeal mass on endolateral view of the neck. (Fig. 2) Spot films showed persistent increase in space between posterior wall of larynx and anterior wall of cervical spine PPD and chest X-rays were negative. The child could swallow and mildly enlarged retropharyngeal lymph nodes were palpated. Patient was treated conservatively and recovered within a few weeks.

Case #2

A three-month-old child presented with retractive stridor, wheezing and respiratory distress. A retropharyngeal mass was suspected on the basis of the original endolateral view. (Fig. 3) The patient has a relatively long neck so that airway buckles extensively on flexion of the neck. The patient also had swallowed at the time the original endolateral view was taken. When the neck was extended and a short series of spot films taken it became apparent that the area was functionally and anatomically normal. (Fig. 4)

This was confirmed by direct laryngoscopy done four days later.

Discussion

The advantages of this technique are that it can be done quickly with any fluoroscopic equipment, requires no preparation, no contrast studies and, in our experience, usually gives sufficient additional information to establish diagnosis.

Of course, other serial filming, such as 70mm, 135mm or cine movies are equally useful. However, special equipment is necessary and in some instances may result in high radiation dosage to the patient. Technical problems particularly applicable to infants includes position of head and neck, whether child is crying or swallowing at time film is taken and phase of respiration. Angulation of the neck, either hyperextending or severely flexing also will alter the relationship of the airway.[5, 8]

Summary

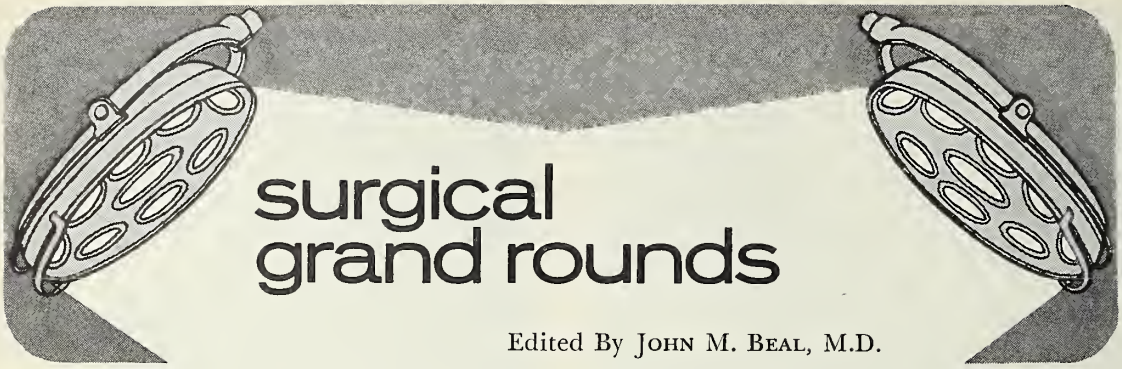
A fluoroscopic spot film technique of obtaining serial endolateral views of the neck is a simple rapid method of diagnosing upper airway obstruction. Various problems secondary to positioning and variations present in young children are circumvented. ◄

References

1. Dunbar, J. S.: "Epiglottitis and Croup." *J. Canad A. Radiologists*, 12, 1967, pp. 86-95.
2. Holinger, P. H.: "Clinicail Aspects of Congenital Anomalies of the Larynx, Trachea, Bronchi and Esophagus." *The J. of Laryng and Otol.* 75, 1961, pp. 1-44.
3. Poole, C. A. and Alman, D. H.: "Acute Epiglottitis in Children." *Amer. J. Roentgen.* 80, 1963, pp. 798-805.
4. Rapkin, R.: "The Diagnosis of Epiglottitis; Simplicity and Reliability of Radiographs of the Neck in the Differential Diagnosis of the Croup Syndrome. *Pediatrics*, 80, 1972, pp. 96-98.
5. Ardran, G. M. and Kemp, F. H.: "The Mechanism of Changes in Form of the Cervical Airway in Infancy." *Med. Radiogr. Photgr.* 44, 1968, pp. 26-54.
6. Dunbar, J. S.: "Upper Respiratory Tract Obstruction in Infants and Children." *The Amer. J. Roentgen.* 109, 1970, pp. 227-246.
7. Wilkinson, R. H.: "Otolaryngologic Radiology in Children, Pediatric Otolaryngology." Vol. II of Disorders of Respirarory Tract in Children. (Edited by C. F. Ferguson, F. L. Kendig) W. B. Saunders, 1972, pp. 833-844.
8. Ardran, G. M. and Kemp, F. H.: "The Nasal and Cervical Airway in Sleep in the Neonatal Period." *Amer. J. Roentgen,* 108, 1970, pp. 537-542.

75 YEARS
Professional Protection
CONTINUOUSLY
Since 1899
THE
MEDICAL PROTECTIVE COMPANY
Fort Wayne, Indiana

CHICAGO AREA OFFICE:
T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives
815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251



Edited By John M. Beal, M.D.

Parietal Cell Vagotomy

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion, Chicago. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of July 17, 1973.

Dr. Maurice Schulten: A 45-year-old male was admitted to the Veterans Administration Research Hospital in June, 1973, with the chief complaint of left lateral chest wall pain after a minor automobile accident three hours earlier. He also related a history of duodenal ulcer treated medically at another hospital six years ago. In the past four years he had had recurrent intermittent epigastric pain relieved by anti-acids. In the month prior to the accident he had had several tarry stools and complained of easy fatigability. He denied nausea, vomiting, hematomesis hematochezia, weight loss and admitted to only an occasional ethanolic beverage.

Physical examination: Blood pressure 130/90 supine, 120/80 standing, pulse 90, respirations 18, temperature 98.9 degrees F. He was a well-developed, well-nourished, alert oriented, cooperative man in no acute distress. His conjuntiva and mucous membranes were pale. There was localized tenderness over the 7th rib laterally on the left side of the chest, but crepitance of the rib was not detected. The breath sounds were decreased to auscultation over the left lower chest. Examination of the heart was normal. The abdomen was not tender and scars, masses or organomegaly were not present. Rectal exam was normal, but the stool was strongly positive for occult blood.

Laboratory studies revealed a hemoglobin of 6.6 gms and a hematocrit of 24%. Chest X-rays were normal and special views of the ribs did not show evidence of fractures. Prothrombin time, platelet count, bleeding and coagulation time were normal. Proctoscopy and barium enema examinations were normal. A radiologic study of the stomach and duodenum was performed.

Dr. Earl Nudelman: Films from June of 1973, show an ulcer crater of the apical portion of the duodenal bulb. There is some post bulbar narrowing. There are no retained secretions and no delay in gastric emptying is noted. (Figure I) Films from January of 1973, show a deformed duodenal bulb. There is no evidence of an active ulcer or obstruction.

Dr. Schulten: Gastroscopy was attempted but only a small superficial prepyloric ulcer was seen. The gastroscopist reported that he could not adequately see the fornices of the duodenal bulb, but that he felt an ulcer crater was present because of mucosal changes and mucoid drainage from the area. Overnight 12-hour gastric collection yielded 1240cc of output with a total acid of 63.3 meq H^+. The basal one hour acid secretion was 1.5 meq H^+/hr and the maximal histolog stimulated secretion was 23 meq H^+/hr.

The patient was maintained on diet manage-



Figure 1. Upper gastrointestinal X-rays demonstrated ulcer in apical portion of duodenal bulb without gastric retention.

ment and anti-acids in the hospital for more than two weeks, but continued to have epigastric pain and occult blood in his stools. Because of the failure of medical management in the hospital, a parietal cell vagotomy without a drainage procedure was performed. His postoperative course was uncomplicated and he was eating by the third day after operation.

The postoperative basal one hour acid secretion was .3 meq H+/hr (an 80% reduction) and the maximal stimulated one hour acid secretion was 19.6 meq/hr (a 26% reduction). The Hollander test was negative, compatible with an adequate vagotomy of the parietal cell mass. One month later, the patient was symptom free and his stools were negative for blood.

Vagotomy was introduced in the treatment of peptic ulcer disease by Dragstedt and Owens in 1943. They performed truncal vagotomy through a transthoracic approach, initially without a gastric drainage procedure. As had been predicted by the work of Latarjet in 1922, approximately 30% of these patients developed gastric stasis due to the decreased motor activity of the stomach. Later, some of these patients developed gastric ulceration. To prevent these complications, a drainage procedure, either pyloroplasty or gastroenterostomy, was added to truncal vagotomy and these procedures have been widely used throughout the United States in the surgical treatment of duodenal ulcer.

However, truncal vagotomy and drainage has been associated with post-prandial diarrhea and the so-called "dumping syndrome" in approximately 10-20%. In 1948, Franksson of Stockholm improvised a new procedure postulating that he could denervate the stomach while preserving the other branches of the vagus nerves. Thus he could reduce the incidence of post-vagotomy symptoms and still reduce gastric acid output. He accomplished this "selective vagotomy" by dividing only the vagus fibers at the gastroesophageal junction and along the lesser curvature of the stomach while maintaining the continuity of the hepatic branch of the anterior vagus and the celiac branch of the posterior vagus nerves. His ideas, however, went unnoticed until 1960 when, in an attempt to reduce the morbidity of vagotomy, Burge of England and Griffith of the United States re-introduced "selective vagotomy." They divided all of the vagus branches to the lesser curvature of the stomach, including the nerve of Latarjet supplying the antrum, and thus reduced the motor activity of the entire stomach without allowing for a drainage procedure. Therefore, they encountered the problems of gastric stasis and recurrent ulceration, much like Dragstedt. Others took the selective vagotomy, added a drainage procedure and thus formulated a procedure which has been used in several centers around the world in the treatment of duodenal ulceration.

In 1960, Ferguson returned to the concepts of Franksson and proposed the use of "parietal cell vagotomy," also called "proximal selective vagotomy," "highly selective vagotomy," "super selective vagotomy," or "acid-fundic vagotomy," in which only the fibers supplying the parietal cell portion of the stomach or the parietal cell mass are divided. The nerve of Latarjet is left intact to supply the antrum and thus maintain motor function and normal gastric emptying. Theoretically, this eliminated the need for a drainage procedure. He also postulated that if the antrum is left innervated, the acid stream acts as an inhibiting factor to gastric acid production. Parietal cell vagotomy has received greater attention in England, Sweden, Norway, Italy and Germany than in this country. Holle and Hart of Germany have performed over 600 of these procedures now and report less than 1% recurrence

and less than 1% incidence of the dumping syndrome.

Thus, three types of vagotomy have been developed in the treatment of duodenal ulcer disease: 1) truncal vagotomy and drainage; 2) selective vagotomy and drainage; 3) parietal cell vagotomy without drainage. A comparison of these three is probably premature at this time because the recent innovation of the selective vagolytic procedures has precluded long term follow-up. However, if one takes the accumulated literature published thus far, and compares the procedures under six major headings, some trend of results in the future can be postulated.

In both truncal and selective vagotomy where a drainage procedure is required, the emptying time of the stomach is greatly decreased, thus dumping a large osmotic load into the small intestine. However, with parietal cell vagotomy, the motor function of the antrum is preserved and thus a drainage procedure is not needed. The pylorus is left intact to function normally and thus the gastric emptying time remains normal.

Although some authors state that the reduction in basal and stimulated acid production is greater with truncal and selective vagotomy, the difference is not substantial. Most authors feel that the level of reduction with all three approaches is well below the level considered to be ulcerogenic. The three procedures, therefore, should be viewed as equal in this regard. The efficiency of parietal cell vagotomy will require longer observation.

The most significant point of comparison of the three procedures involves the incidence of post vagotomy symptoms. With the truncal vagotomy and drainage, the incidence of dumping syndrome is reported to be approximately 15-20% one year after operation. When selective vagotomy and drainage is performed, the incidence is reported to range from 10 to 18%, not an impressive improvement over truncal vagotomy. However, the reports of parietal cell vagotomy without drainage procedures indicate an incidence of post vagotomy symptoms of less than 2%.

It is difficult to make a comparison of these three procedures in regards to recurrence of ulceration because of the lack of good long term follow-up for the selective vagolytic procedures. However, from current reports, it would appear that the recurrence rate is at least as low if not lower with the parietal cell vagotomy as with the other two procedures. The reported recurrence with truncal vagotomy and pyloroplasty

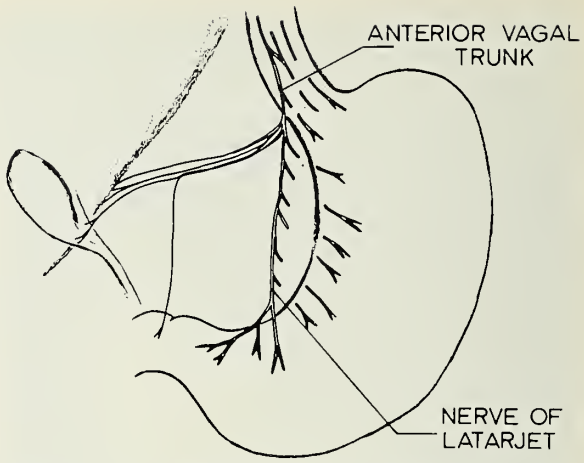


Figure 2. Diagrammatic representation of division of vagal fibers along lesser curvature of stomach.

range from 3-12%. For selective vagotomy with a drainage procedure, so far reports vary from .7 to 3%. Parietal cell vagotomy promoters report only a .3 to 1% recurrence rate. The largest series of parietal cell vagotomies reported by Holle and Hart reports a 1% recurrence rate.

As judged by the Hollander test, the completeness of vagotomy accomplished by parietal cell vagotomy is consistent with the other procedures in the reports to this time. The mortality rate under elective conditions is less than 1% for all three procedures.

Dr. John Beal: Dr. Schulten has emphasized the importance of preserving the normal emptying mechanism of the stomach. Vagotomy and drainage has had the important advantage of a lower mortality rate than has gastric resection or vagotomy and resection for most surgeons, although recurrent ulceration may occur more frequently with vagotomy and drainage. The hope that gastrointestinal disturbances would be less frequent after vagotomy and pyloroplasty than after resection has not been realized, although post-prandial problems are often less severe after vagotomy and drainage. Anytime that the integrity of the pylorus is lost, whether by removal as in resection or by division in pyloroplasty, the patient is likely to develop certain post-prandial disturbances, such as "dumping," diarrhea, cramping, nausea and vomiting.

Parietal cell vagotomy has two particular advantages. The preservation of the innervation of the antrum and duodenum results in normal gastric emptying. The absence of an opening into

(Continued on page 360)

Doctor's News

Special House Session Rejects PSRO



ISMS Delegates and Trustees are pictured during the special House of Delegates Session that rejected PSRO and directed ISMS to develop own review plan. During the one-day session, February 24, the delegation voted to "refrain from involvement" in federal PSRO initiatives and urged medical care foundations in the state which have sought PSRO designation to withdraw their applications "in the interest of consistency, unity and strength."

EMERGENCY MEDICINE CLINICAL CONFERENCE, APRIL 18-20—The Illinois Chapter, American College of Emergency Physicians and the Division of Emergency Medicine, University of Chicago, are sponsoring a clinical conference on emergency medicine, April 18-20, at the Ambassador Hotels, Chicago. The program is acceptable for 12 elective hours by the American Academy of Family Physicians; accredited toward Physicians Recognition Award, AMA; and accredited for Continuing Medical Education requirements of ACEP. For further information, contact: Illinois Chapter, ACEP, 836 W. Wellington Ave., Chicago 60657.

CREDIT, COLLECTIONS SEMINAR SCHEDULED APRIL 22—"Credit & Collections" are the subjects of a one-day symposium on April 22, 1974, in Chicago by Medical Group Management Assn., Denver. Major topics include billing systems, processing of third-party claims, services and finance charges, collection of difficult accounts and legislation affecting credit billing operations. For details call Ozzie Wolfes, Orthopedic Associates, Arlington Heights; phone (312) 392-4320.

CONGRESS ON CME SLATED APRIL 18—The second annual Illinois Congress on Continuing Medical Education will be held April 18, at the Oak Brook Hyatt House, Oak Brook. The one-day Congress, sponsored by the Illinois Council on Continuing Medical Education, will show CME planners how to identify their colleagues' needs and in turn the planners will have the opportunity to tell about learning problems in their hospitals, specialty societies and other medical organizations.

This Congress is accredited for seven hours of AMA Category I credit. Registration is limited and the cost of tuition is $25. For information, write ICCME, 360 N. Michigan, Chicago, Ill. 60601.

ISMS Physicians Active In Radio-Television Speakers Bureau



Israel Davidsohn, M.D., (right) noted hematologist and researcher, discussed early cancer detection on the radio series, "Your Doctor Speaks."

Physician spokesmen for ISMS will log an estimated 1,000 hours of on-the-air time during 1974 because of increased activity by the Radio-Television Speakers Bureau.

More than 30 physicians will be seen and heard through a cooperative effort involving ISMS and the University of Illinois Office of Public Information, which produces syndicated radio and TV programs carried by 169 broadcast outlets in several states.

Placement of ISMS members on the radio show, "Your Doctor Speaks," produced by Keith Fearon, will account for more than 400 broadcast hours. The program is syndicated to 49 stations in 19 states. Speakers on the TV show, "Consultation," which is carried by 120 stations in 38 states, will mark up about 600 hours.

Twenty of the radio stations carrying the 25-minutes discussion show in Illinois are:

WKRO Cairo
WCAZ Carthage
WAIT Chicago
WDHF-FM Chicago
WFMF Chicago
WEPS Elgin
WEAW Evanston
WFIW Fairfield
WFRL Freeport
WEBQ Harrisburg
WKAN Kankakee
WTAQ LaGrange
WLCC Lincoln
WOUA Moline
WBBA Pittsfield
WTAY Robinson
WJBD Salem
WCLR Skokie
WMAY Springfield
WKRT Cortland

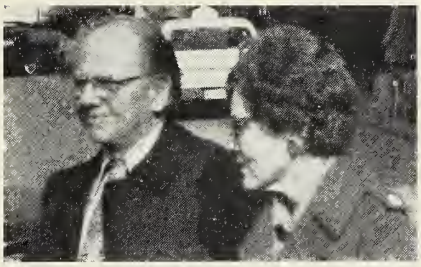
Physicians representing ISMS are Drs.: **Max Klinghoffer,** G.P., Elmhurst; **Jack Weinberg,** psychiatrist, Chicago; **Max Sadove,** anesthesiologist, Chicago; **Richard Cook,** psychiatrist, Chicago; **Leon Unger,** allergist, Chicago; **Richard Sassetti,** hematologist, Chicago; **Israel Davidsohn,** hematologist, Chicago; **Marshall Blankenship,** dermatologist, Chicago; **Ted Fox,** orthopedist, Chicago; **Joseph Skom,** internist, Chicago; **Jakub Schlicter,** internist, Chicago; **John Ballinger,** otolaryngologist, Winnetka; **Richard Marcus,** otolaryngologist, Skokie; **Sheldon Berger,** internist, Chicago; **Angelo Creticos,** internist, Chicago; **Edwin DeCosta,** obstetrician/gynecologist, Chicago; **Seymour Diamond,** neurologist, Chicago; **Michael Jerva,** neurologist, Chicago; **Harvey Kravitz,** pediatrician, Morton Grove; and **Eugene Diamond,** pediatrician, Chicago.

WASHINGTON ROUNDUP '74

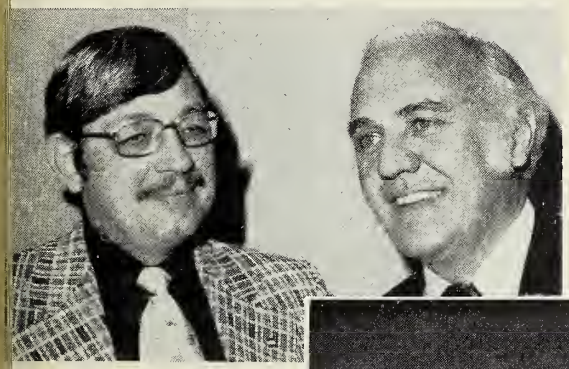
The 1974 ISMS Washington Roundup drew a total of 107 people to the nation's capital for a series of meetings between the leadership of organized medicine in Illinois and representatives of the federal government. Highlights of the annual event included a briefing by the AMA staff in Washington, D.C.; a meeting with Secretary of Health, Education and Welfare, Casper Weinberger; and the annual ISMS Congressional Reception.



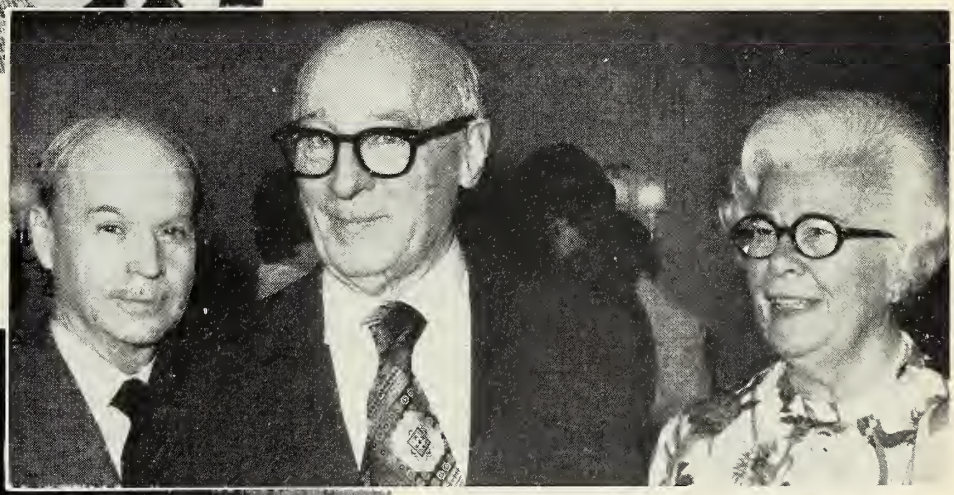
ongressman Harold Collier and Frank J. Jirka, I.D., at the 1974 Congressional Reception.



Top: Dr. and Mrs. Donovan Wright were among those in attendance at the Washington Roundup. Left: Albert Ray, M.D., Joliet, chats with Congressman George O'Brien.



ght: Dr. and Mrs. Wil-d C. Scrivner, Belleville, lked with their district ongressman Melvin Price nter).





ngressman Edward J. Derwinski (left) and Philip Thomsen, M.D., Dolton, visited during the Con- ssional Reception.



A group heads to the meeting with Casper Weinberger, Secretary of HEW.

IN GONORRHEA

INJECTION

Wycillin®

(STERILE PROCAINE PENICILLIN G SUSPENSION) WYETH

Gonorrhea, according to the national Center for Disease Control, is, if the parenteral route is chosen, most effectively treated with aqueous procaine penicillin G. In uncomplicated cases, administration of 4.8 million units together with 1 gram oral probenecid, given at least 30 minutes prior to injection, is recommended.

Indications: In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae:* acute and chronic (without bacteremia).

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity. Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported. (See "Warnings.")

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Administer only by *deep intramuscular injection,* in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal infections (uncomplicated)—Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

NOTE: Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units. I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae.* Follow-up treatment consists of 4.8 million units daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Composition: Each TUBEX® disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.7% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. polyvinylpyrrolidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Five are graduating with honors. How many with VD?

On the average, you can figure the incidence of VD among teenagers at about 900 per 100,000 population.* And growing.

Among those in the 20-24 age-group, the incidence is even higher. And it, too, is growing.

In the long run, a populace educated to the risks and prevention of VD is probably the best answer to the problem. Meanwhile, though, adequate doses of the recommended types of penicillin remain a formidable weapon.

IN SYPHILIS

INJECTION

Bicillin® LONG-ACTING

(STERILE BENZATHINE PENICILLIN G SUSPENSION) WYETH

Syphilis is preferably treated with benzathine penicillin G, which is also the drug of choice for prophylaxis after exposure. Administration of 2.4 million units (1.2 million in each buttock) usually cures most cases of primary, secondary and latent syphilis with negative spinal fluid.

Indications: In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms including fungi. Take appropriate measures should superinfection occur.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

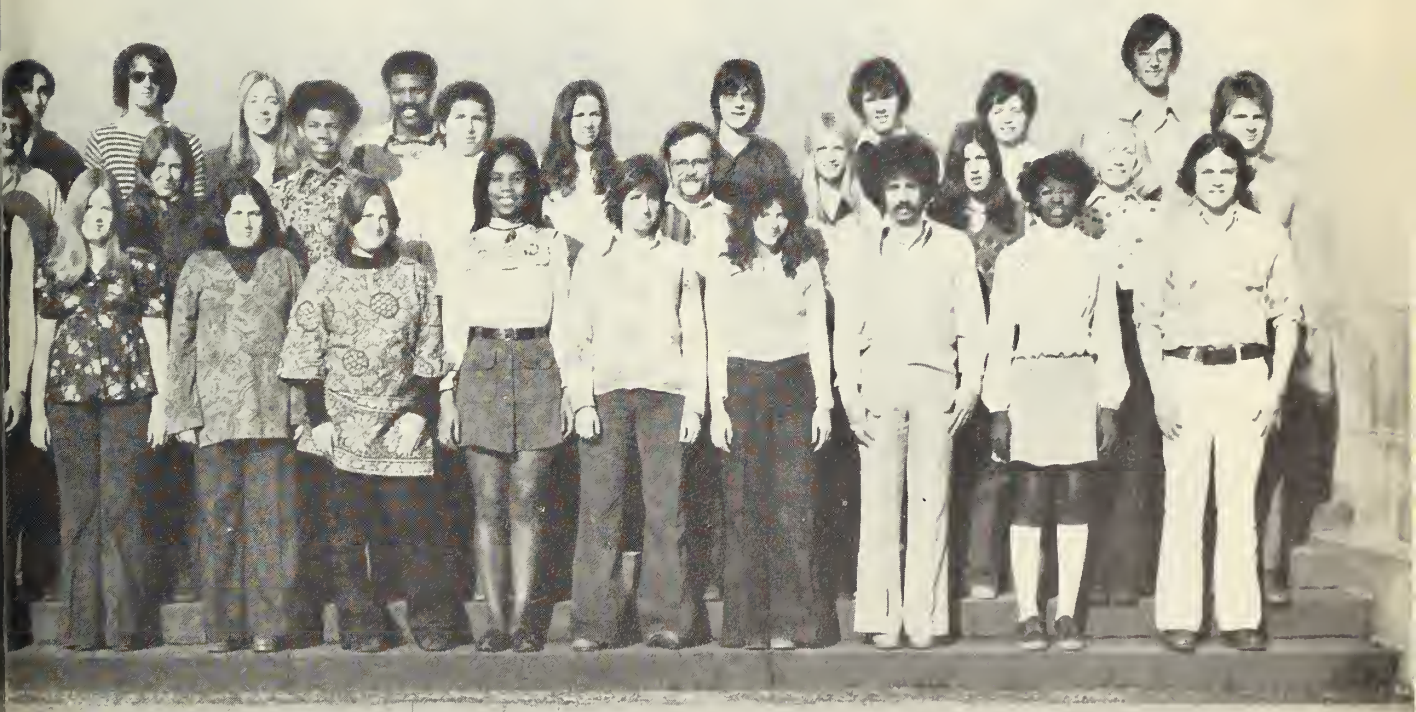
Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

Congenital—under 2 years of age, 50,000 units/Kg. body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

(Shake multiple-dose vial vigorously before withdrawing the desired dose.) Administer by **deep intramuscular injection** in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

Composition: 2,400,000 units in 4-cc. single dose disposable syringe. Each TUBEX disposable syringe also contains in aqueous suspension with sodium citrate buffer, as w/v approximately 0.5% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. Units benzathine penicillin G (as active ingredient); 300,000 units per cc.—10-cc. multi-dose vial. Each cc. also contains sodium citrate buffer, approximately 6 mg. lecithin, 3 mg. polyvinylpyrrolidone, 1 mg. carboxymethylcellulose, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Wyeth Laboratories
Philadelphia, Pa. 19101
™



*U.S. Dept. of Health, Education, and Welfare: VD Fact Sheet 1972. Publication No. (HSM) 73-8195.

Control of Habit-Forming Drugs

Parallel federal and state laws now control the flow of medications which have abuse potential to a greater degree than ever before. While the laws are parallel, they are not identical; thus, confusion is created for physicians and pharmacists. In an effort to simplify compliance, the charts, were prepared by the Illinois Pharmaceutical Association and the Chicago Retail Druggists' Association. Please note that the storage and order form requirements apply to physicians as well as pharmacists. Additional label and record keeping requirements are imposed on physicians who dispense take-home supplies of contolled substances.

Where prescriptions are refillable, the prescriber may designate up to five refills, and these may be honored by the pharmacists during a period of six months. No quantity restrictions are imposed by the law, but pharmacists will generally question controlled substance prescriptions for more than one hundred dosage units. Physicians may obtain controlled substances for office use from pharmacists by using the federal order form. At the present time, Valium, Librium and Darvon are NOT controlled substances.

The Illinois Medical Journal expresses its appreciation to Roger W. Cain, R.Ph., Executive Director, Illinois Pharmaceutical Association for his assistance in developing these materials.

CONTROLLED SUBSTANCES REFERENCE CHART

	Federol Schedule Number	Requires Official Triplicote Rx	Requires Written Rx Signed by MD	Refill Stotus	Federal Order Form Required	Security Locked Cobinet
Old Class "A" Narcotics (Morphine, Demerol, Diloudid, etc.)	II	YES	YES	NO	YES	YES
Methamphetamines and all combinations. (Desoxyn, Phelontin, etc.)	II	YES	YES	NO	YES	YES
Amphetamines and all combinations. (Dexedrine, Eskotrol, Bomodex, etc.)	II	YES	YES	NO	YES	YES
Methaqualone. (Quoolude, Sopor, Porest, etc.)	II	YES	YES	NO	YES	YES
Methylphenidate (Ritolin) **Phenmetrazine** (Preludin)	II	NO	YES	NO	YES	YES
Injectable & oral forms of amobarbital, pentobarbital, & secobarbital, all combinations with each other and with other controlled drugs. (Tuinol, etc.)	II	NO	YES	NO	YES	YES
Old Class "B" Narcotics (Empirin Comp/Codeine, Hycomine, Phenophen with Codeine, etc.)	III	NO	phone orders occeptoble	5 times or 6 months as indicoted by MD	NO	NO
Schedule III drugs (Sonorex, Voranil, Plegine, Butobarbital, Poregoric, Gemonil, Doriden, etc. Also Nembutal ond Seconol Suppositories)	III	NO	phone orders occeptoble	5 times or 6 months os indicoted by prescriber	NO	NO
Schedule IV drugs (Tenuote, Teponil, Ionomin, Phenobarbitol, Meprobomote, etc.)	IV	NO	phone orders occeptoble	5 times or 6 months os indicoted by prescriber	NO	NO

CONTROLLED SUBSTANCES REQUIREMENTS

Drug	Triplicate Rx Required	Written Rx Required	Refill ?	Federal Order Form Required	Locked Security Required
Amobarbital Oral & Inj.	NO	YES	NO	YES	YES
Amphetamine	**YES**	YES	NO	YES	YES
Amytal	NO	YES	NO	YES	YES
Amytal & Aspirin	NO	NO	YES	NO	NO
APC w/Demerol	**YES**	YES	NO	YES	YES
Bamadex Sequels	**YES**	YES	NO	YES	YES
Benzedrine	**YES**	YES	NO	YES	YES
Biphetamine	**YES**	YES	NO	YES	YES
Butabarbital	NO	NO	YES	NO	NO
Butisol	NO	NO	YES	NO	NO
Codeine Tablets	**YES**	YES	NO	YES	YES
Demerol	**YES**	YES	NO	YES	YES
Desoxyn	**YES**	YES	NO	YES	YES
Dexamyl	**YES**	YES	NO	YES	YES
Dexasequels	**YES**	YES	NO	YES	YES
Dexedrine	**YES**	YES	NO	YES	YES
Dextro-Amphetamine	**YES**	YES	NO	YES	YES
Didrex	NO	NO	YES	NO	NO
Dilaudid	**YES**	YES	NO	YES	YES
Dolophine	**YES**	YES	NO	YES	YES
Emesert Suppository	NO	NO	YES	NO	NO
Empirin w/Codeine	NO	NO	YES	NO	NO
Ephedrine & Amytal	NO	NO	YES	NO	NO
Eprogen	NO	NO	YES	NO	NO
Eskatrol	**YES**	YES	NO	YES	YES
Hycodan Tablets	NO	NO	YES	NO	NO
Hycomine	NO	NO	YES	NO	NO
Ionamin	NO	NO	YES	NO	NO
Leritine	**YES**	YES	NO	YES	YES
Mebaral	NO	NO	YES	NO	NO
Mediatric	**YES**	YES	NO	NO	NO
Mepergan	**YES**	YES	NO	YES	YES
Meperidine	**YES**	YES	NO	YES	YES
Methadone	**YES**	YES	NO	YES	YES
Methamphetamine	**YES**	YES	NO	YES	YES
Methaqualone	**YES**	YES	NO	YES	YES
Monothemine & Amytal	NO	NO	YES	NO	NO
Morphine	**YES**	YES	NO	YES	YES
Nebralin	NO	NO	YES	NO	NO
Nembu-Donna 1/2	NO	NO	YES	NO	NO

Drug	Triplicate Rx Required	Written Rx Required	Refill ?	Federal Order Form Required	Locked Security Required
Nembutal Oral & Inj.	NO	YES	NO	YES	YES
Nembutal Suppository	NO	NO	YES	NO	NO
Obetrol	**YES**	YES	NO	YES	YES
Optimil	**YES**	YES	NO	YES	YES
Paregoric	NO	NO	YES	NO	NO
Parest	**YES**	YES	NO	YES	YES
Pentobarbital w/Aspirin	NO	NO	YES	NO	NO
Pentobarbital Oral & Inj.	NO	YES	NO	YES	YES
Pento-Del	NO	YES	NO	YES	YES
Percodan	**YES**	YES	NO	YES	YES
Phelantin	**YES**	YES	NO	NO	NO
Phenaphen w/Codeine	NO	NO	YES	NO	NO
Phenobarbital	NO	NO	YES	NO	NO
Plegine	NO	NO	YES	NO	NO
Ponderex	NO	NO	YES	NO	NO
Preludin	NO	YES	NO	YES	YES
Pre-Sate	NO	NO	YES	NO	NO
Quaalude	**YES**	YES	NO	YES	YES
Qui-A-Zone	NO	YES	NO	YES	YES
Ritalin	NO	YES	NO	YES	YES
Sanorex	NO	NO	YES	NO	NO
Secobarbital Oral & Inj.	NO	YES	NO	YES	YES
Seco-8	NO	YES	NO	YES	YES
Seconal Oral & Inj.	NO	YES	NO	YES	YES
Seconal Suppository	NO	NO	YES	NO	NO
Soma Cmpd. w/Codeine	NO	NO	YES	NO	NO
Somnafac	**YES**	YES	NO	YES	YES
Sopor	**YES**	YES	NO	YES	YES
Synatan	**YES**	YES	NO	YES	YES
Synatan Forte	**YES**	YES	NO	YES	YES
Tenuate	NO	NO	YES	NO	NO
Tepanil	NO	NO	YES	NO	NO
Tribarbs	NO	YES	NO	YES	YES
Tuinal	NO	YES	NO	YES	YES
Tussend	NO	NO	YES	NO	NO
Tussionex	NO	NO	YES	NO	NO
Tylenol w/Codeine	NO	NO	YES	NO	NO
Voranil	NO	NO	YES	NO	NO
Wilpo	NO	NO	YES	NO	NO

Prescribing Physical Therapy

Widespread misunderstanding of physical treatment services reimbursable under Medicare and other third party sources prompted the ISMS Board of Trustees to approve guidelines to help M.D.s better prescribe and evaluate these services.

Because of continuing reports that unauthorized personnel are performing physical therapy, the ISMS Board urges members to notify ISMS of specific instances of such abuse. The information will be forwarded to the Department of Registration and Education.

These guidelines were first published in 1970, and are as follows:

Requirements for Physical Therapy Services Reimbursable Under Medicare.

1. The physician in communication with the physical therapist, must prescribe (authorize in writing) the specific means or methods to be used by the therapist and the frequency of therapy services.
2. Physical Therapy must be related to the active treatment regimen designed by the physician to elevate the patient to his maximum level of function which has been lost or reduced by reason of injury or illness.
3. "Physical therapy as needed" or a similarly worded blanket authorization does not suffice as an accepted prescription since no specific treatment is named and the physical therapist is in effect prescribing the patient's regimen.

Distinction Between Physical Therapy Services and Restorative Nursing Care.

1. Restorative nursing care includes such measures as maintaining good body alignment and proper positioning of bedfast patients, keeping patients active and out of bed in accordance with the physician's orders, and developing the patient's independence in activities of daily living by teaching self-care, transfer and ambulation activities on the nursing unit.
2. Nursing personnel may also assist patients in practicing the use of prosthetic and orthotic devices and in carrying out the prescribed physical treatment if requested by the physician.
3. Restorative nursing procedures performed by licensed nurses constitute a part of skilled nursing care when they are prescribed by a physician and are designed to restore functions which have been lost or reduced by illness or injury.

Recommendations When Prescribing All Physical Treatment Services.

1. The physician should place detailed orders for all allied health professions in the patient's chart prior to the treatment being initiated, specifying goals or potentials. This implies that the physician should designate the person or department to supply the physical treatment services, such as physical therapy, occupational therapy, nursing, etc.
2. The physician should ask the physical therapist, or others of the allied health professions, to file notes in the patient's chart similar to nursing notes at least weekly, reflecting the patient's response to treatment.
3. The physician should review the patient's record at least every two weeks to determine if treatment is being provided according to his orders. Treatment that is being provided, but which has not been prescribed or authorized by the physician, should be discontinued immediately.
4. Formal physical and occupational therapy is not indicated when evidence indicates that similar types of care could be provided on the nursing unit by rehabilitative nursing or other techniques.
5. Over-utilization of health service is a problem which physicians, allied health professions, and third-party sources realize exists. It is the responsibility of the physician to insure that proper treatment is provided but that unnecessary treatment and over-utilization of health services is avoided. ◄

The post-T&A patient:
another type for Tylenol®
(acetaminophen)



When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.[1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding....Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL'—that is, patients who should avoid aspirin. Considering all of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL (acetaminophen) routinely for simple analgesia?

References: 1. Reuter, S. H., and Montgomery, W. W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J. B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A. D., and Pearson, H. A.: J. Pediat. *78*:558-560 (March) 1971.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. TYLENOL (acetaminophen) has rarely been found to produce any side effects.

Elixir, 120 mg./5cc. (alcohol 7%).
Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin,
yet just as effective for relief
of pain and fever

Tylenol®
(acetaminophen)

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

© McN. 1973

Treatment of Children With Burns

John G. Raffensperger, M.D. and William J. Pokorny, M.D./Chicago

Generations of mothers have admonished their children, "Hot, don't touch;" there is legislation against flammable clothing; and electric lights have replaced candles; yet burns are still a common cause of injury in children.

Nothing else causes such a major physiologic and psychologic upset in a child, since every organ system is affected by a major burn. Not only is a burn disastrous for the child and his family, but even a relatively minor burn treated on an outpatient basis is trying to medical personnel. Burned children require unstinting care by a well-organized team of surgeons, nurses, physical therapists and dietitians. The hospital which undertakes the care of these children must not only have trained, patient and kind personnel, but must be willing to provide expensive space and equipment. Certainly not every hospital should accept burned children.

In each age group, there seem to be characteristic patterns of injury due to burns. The typical burn in a baby is often scalding due to untested bath water drawn by a negligent baby sitter. Toddlers pull boiling liquids off the stove down onto their head, face and shoulders. Boys five to ten years old have an affinity for matches and cans of gasoline in the garage. Anyone who has seen the results of such a burn is quite willing to go back to hand-propelled lawn mowers to avoid keeping gasoline. Either because they are not as well-supervised, or because playing with matches is a symptom of emotional disturbance, children from broken homes are more likely to have serious burns. The resulting parental guilt is another factor with which the understanding physician must deal.

Children with burns of less than 10% may be treated on an outpatient basis. However, those with facial, hand or perineal burns, and those under one year of age should be admitted to the hospital. When deciding on outpatient care, it is necessary to take into consideration the family's stability and intelligence.

JOHN G. RAFFENSPERGER, M.D., is head of the Division of General Surgery at Children's Memorial Hospital, Chicago and WILLIAM J. POKORNY, M.D., is a Senior Resident in Pediatric Surgery at Children's Memorial Hospital.

Outpatient Therapy

1. Immerse the burned area in cool water or apply cold, wet sterile towels to the burn area for analgesia and give a systemic analgesic.
2. Wash and debride the area with bland soap and water.
3. Remove loose skin and blisters with sterile technique.
4. Apply a single layer of non-adherent fine mesh gauze (vaseline, Adaptic, Furacin) and cover with a large bulky dressing held in place securely with large amounts of adhesive tape or stockinette.
5. Administer tetanus immunization.

Although some doctors treat small burns with the open technique on an outpatient basis, we prefer occlusive dressing, because of the greater protection against further trauma and more security for the patient and his family. Systemic antibiotics are usually not required for uncomplicated small burns treated on an outpatient basis.

The family is instructed to bring the child back in five days unless there is fever or drainage from the dressing, in which case they should return immediately to have the dressing changed. At five days, the outer dressing is removed down to the layer of fine mesh gauze. If the wound is clean with no odor or pus, it is again rewrapped and the patient returns every three to four days. If the burn is third degree, he should be admitted to the hospital at this time for debridement and grafting. By 10-14 days, the entire dressing is soaked off with warm saline or soapy water. The adherent dressing should *never* be forcefully removed; this tears off new epithelium and may convert a healing partial thickness burn to one requiring a skin graft. Following healing of partial thickness burns, a bland ointment will relieve itching, thereby protecting the new thin epidermis from further trauma.

Care of Major Burns

Evaluation:

The child should be entirely undressed to

avoid missing burned areas. While a nurse checks height and weight, a physician should take a rapid but meaningful history specifically to learn about associated illnesses and allergies. A rapid evaluation of the child's injuries is made as follows:

Airway. Flame burns about the face or a history of flames in a closed space suggest a respiratory burn. Singeing of the nasal vibrissae, hyperemia of the oral or nasal mucosa, and a hacking cough are further indications of an airway problem. Symptoms of bronchorrhea or obstruction due to edema of the upper airway may not become evident for six hours or longer after the burn, and then may develop as an emergency. For this reason all patients with a history or physical findings suggesting a respiratory burn should be admitted to the hospital. Restlessness, wheezing or associated injuries to the face, head and thorax may indicate a prompt tracheotomy over an endotracheal tube.

Extent and depth of the burn. A chart should be constructed showing both the anterior and posterior body surfaces with the area of burn. The standard rule of nines must be modified for children as follows, since the head and trunk have a relatively larger surface area than in adults.

	Newborn	*3 years*	*6 years*	*10 years and over*
Head	18%	15%	12%	9%
Trunk	40%	40%	40%	35%
Each arm	8%	8%	8%	9%
Each leg	13%	15%	16%	18%

It is difficult and perhaps not necessary to determine the burn depth during early post-burn period, but in general a brown or white surface indicates full thickness tissue damage, while blistering suggests a partial thickness burn.

Initial Resuscitative Therapy

1. Draw blood for hematocrit, type and cross match, electrolytes and BUN.
2. Start intravenous Ringers lactate solution and calculate fluid needs.
3. Insert a Foley catheter in all children with a burn over 30%, or with burns to the perineum.
4. Pass a nasogastric tube.
5. Give tetanus prophylaxis particularly for perineal burns.
6. Give Penicillin, for the first seven days, due to the danger of betahemolytic streptococcal cellulitis and septicemia during this period.
7. Give intravenous sedation if the child is in pain or restless and it has been determined that the airway is not involved. For children over one year of age, 0.1 mg/kilo of morphine may be given intravenously. If it is convenient to dilute 5 mg of morphine with 10 cc of saline, then give increments of 0.25 mgs (1 cc) until pain relief is achieved.
8. Start an intensive care flow sheet to record pulse, blood pressure, respiratory rate and urine output every half hour. The initial fluid therapy is calculated and recorded as follows according to the Brooke Army formula (Table 1).

The volume and timing of fluid administration is based on the time the child was burned and not when he was admitted to the hospital. If there is a delay, the child might well be in shock and therefore require a rapid push of I.V. fluid (15 cc/kilo). During the early post-burn period, an infusion of 300 ml/m^2/hr of Ringers or saline solution may be necessary to obtain adequate tissue perfusion and urine flow. The urine volume must be at least 30-40 cc/m^2/hr (1 cc/lb/hr). The evaporation through the burn wound reaches a maximum at about 24 hours post-burn in partial thickness burns and on the fourth day post-burn in full thickness burns. This may be as much as 300 ml/m^2/hr and usually is in the range of 100-150 ml/m^2/hr.[7]

At present, there is a trend away from giving colloid solutions during the first 24-36 hours.[2,5] This is due to an increase in capillary permeability and a decrease in the osmotic properties of albumin in the vascular space. After 36-48 hours, normal permeability is restored in the capillary endothelium and colloid should be given.

Due to a large sodium load during resuscitation, an excess of total body sodium exists and after this phase, dextrose in water with potassium is given. At approximately 48-72 hours, a diuresis begins with mobilization of edema fluid. Bruck[2] has found an increase of 10-15% and as much as 20% of body weight during fluid resuscitation and some weight loss daily thereafter for the first ten days post-burn. By 72 hours post-burn, fluid can be administered according to the patient's state of hydration, weight, serum sodium and osmolarity. The serum sodium can be maintained between 135-140 mEq/liter and the serum osmolarity at 275-285 mOsm/liter.

The burned patient continues to lose huge volumes of fluid through the burn wound (in-

cluding the dry, leathery eschar) at a rate of 2-3.1 ml/Kg% burn until the wound is grafted.[4] The fluid losses from second and third degree burns are similar.

Care must be taken in infants and small children to prevent overhydration and imposing too heavy a solute load on the patient's kidney. Infants and small children poorly tolerate large fluctuations in osmotic and solute loads and must be observed closely for changes in hydration and serum sodium.

Infants with severe burns may have hemoconcentration during the first 24-48 hours. However, many small children present with physiologic anemia and iron deficiency anemia. The hematocrit should be maintained above 40%.

By 48-72 hours post-burn, the patient is usually able to take fluids by mouth. If he continues to be anorexic, but with good bowel function, he should be fed by nasogastric tube. Due to the recurrence of ileus with sepsis and stress, nasogastric tubes should never be clamped in burned patients, but may be elevated.

Environment

Heat production of the body of the burn patient is closely related to the evaporative losses of that patient. Each milliliter of water vaporized requires 0.576 kilocalories of heat which must be produced by the body in order to maintain thermal equilibrium. For an adult, a maximum energy requirement of 5,000 kilocalories/day has been measured.[4]

The severely burned child has poor thermal control, and hypothermia is a common feature during the first week post-burn as well as under general anesthesia.[3] This can also occur later when the patient undergoes general anesthesia for debridement and graftings.

By maintaining an environmental temperature at 32°C with a low relative humidity, Barr et al[1] found a marked decrease in the basal metabolic rate despite increased evaporative losses. The heat of vaporization comes from the environment and the patient's own energy is conserved for the healing process.

Burn Wound Care

Initially, while the child is being resuscitated, merely cover him with sterile sheets. When his vital signs are stable and he is putting out 1 cc/lb/hr of urine, care of the wound can start:

1. Shave all hair near the burned area.
2. Wash the affected areas with aseptic technique, using betadine soap and water.
3. Remove obviously loose skin.
4. Apply sulfamylon with the gloved hand hand as one would "butter" bread.
5. Keep the child under a tent of sheets which is warmed with a heat lamp.

Studies at the Brooke Army Medical Center have clearly demonstrated a decreased incidence of burn wound sepsis with sulfamylon.[8] A significant decrease in the mortality rate in children with burns of less than 60% has also been documented since the introduction of sulfamylon in 1964 at Brooke.[2] However, sulfamylon creates a problem in acid base control with development of hyperchloremia and acidosis. The patients may develop severe metabolic acidosis due to the high acid load of sulfamylon and its breakdown products as well as inhibition of the carbonic anhydrate system. This impairs the effectiveness of the renal tubular buffering mechanism to maintain normal body pH. These children then develop a compensatory respiratory alkalosis with a normal serum pH. Therefore, when a child hyperventilates, sulfamylon should be discontinued for two to three days.

Sulfamylon, by inhibiting bacterial growth beneath the eschar, may delay the eschar separation by approximately 1-2 weeks. Overgrowth of candida has also been reported with increasing frequency in the use of sulfamylon.

Sulfamylon results in a significant reduction in the evaporative water loss from the burn wound, due to the fact that the vehicle in which it is produced is 62% water. Due to the decrease in evaporation as well as reduced incidence of wound sepsis, the metabolic rate reduction is in the range of 50-75% that of an untreated large burn, and weight loss only 10-15% of the pre-burn value, instead of 25-40% previously reported in burned patients.[8]

Circumferential deep burns of extremities may constrict circulation just as a tight cast; also, chest burns restrict respiration and cause atelectasis. Cyanosis, pallor or coolness of the toes and fingers are an indication for escharotomy. This is performed by incising the full thickness burn wound down to the fat with a scalpel, the entire length of the involved extremity on either side. Edema will separate the burned skin and the resulting open wound is liberally covered with sulfamylon. A circumferential chest burn may require escharotomy in several places or even an emergency full thickness debridement.

By 48 hours post-burn, the typical child has recovered from his ileus, will start to eat and generally looks surprisingly well. It is easy to be lulled into false security by the child's ap-

pearance. At this time, the child will benefit from frequent visits from his family. His mother and the dietitian should plan with the nurses a tasteful, high-calorie, high-protein diet. It may be necessary to use hot dogs and milk shakes rather than standard hospital fare, and to supplement oral intake with nightly tube feedings. Extra vitamins and ascorbic acid are also essential. Great patience, including rewards and threats are essential to encourage the child to eat, since the burn is such a tremendous drain on the metabolism.

Surgical excision, under ketamine anesthesia, is still satisfactory treatment for small burns. In larger burns, daily tub baths and frequent superficial excisions of dead tissue will hasten eschar removal. Excision of the superficial layers of dead tissue with a dermatone will prevent abscess formation under the tough outer eschar.

It may become necessary to substitute saline dressings for sulfamylon to hasten eschar separation. Skin grafting may be started as the dead tissue separates, and heterografts of pig skin are tremendously useful as a temporary biological dressing prior to skin grafting. Malnutrition and sepsis go hand in hand; it is often a race between these two specters and final skin coverage.

Rehabilitation

Rehabilitation of the burned child may take years, but should be started early in his hospital course. He can be encouraged to exercise his hands and legs in the whirlpool bath prior to skin grafting and as soon as possible after "take" of the grafts.

Joints should be splinted in extension when the burns involve flexion surfaces, such as the antecubital space, popliteal fossa and the axilla The hand is splinted in the position of function, except in instances in which there is a burn to the dorsum of the hand, in which case the hand should be splinted in such a way as to prevent adhesions of the extensor tendons, and maintain flexion of the metacarpal phalangeal joints. This is done with the metacarpal phalangeal joint in maximum flexion with the interphalangeal joint in slight flexion, with the thumb maximally abducted. Skeletal deformity following burns is greater among children because a growing bone will yield to the stresses placed upon it by soft tissue constraints. For this reason, mild contraction of the hands and feet and scars of the paraspinal areas should be corrected as soon as possible to avoid permanent skeletal deformities.[6]

Psychological Care

It is often difficult for nurses and physicians to stay cheerful in the presence of a severely burned child, but everything possible must be done to encourage the patient. Parental visitation is encouraged, television is a godsend and school work is helpful. As soon as the danger of infection is past, the child can go to the playroom or stay with other children on the ward.

Mortality Rate From Burns

With rapid resuscitation, topical agents such as sulfamylon, heterografts, homografts, environmental control and more recently, parenteral alimentation,[9] there has been an overall decrease in burn mortality rate, particularly in the group with less than 60% burns. Burns over 60% still carry a tragically high mortality rate, approaching 80-100%. ◀

References

A complete bibliography for "Treatment of Children With Burns" may be obtained by writing to the *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago 60601.

Table I

FLUID CALCULATION—
FIRST 24 HOURS POST BURN
For burns over 50%—use 50 in formula

BROOKE FORMULA

Electrolyte: = 1.5 × Wt in Kg × percent of burn _____

Colloid: = 0.5 × Wt in Kg × percent of burn _____

estimate for first 24 hours _____

MAINTENANCE

1,200 cc/M_2 or:
100 cc/Kg 5% D/W — up to 10 Kg
1000 + 50 cc/Kg — up to 10-15 Kg
1000 + 250 + 20 cc/Kg — over 15 Kg
2000 — over 12 years

Date and time of burn: **Weight:**
Initial Hematocrit:

	50%	25%	25%
Totals:			
Electrolyte:	_____	_____	_____
Colloid:	_____	_____	_____
D_5w	_____	_____	_____
TOTALS:	_____	_____	_____
	50%	25%	25%

Hr. First 8 Hrs.	Hr. Second 8 Hrs.	Hr. Third 8 Hrs.
_____	_____	_____

Signature: _____

When Prices Go Up And Down At The Same Time, Something's Just Gotta Be Wrong. Right?

Riddle: When is a price increase *not* a price increase? Until a few days ago, we would have assumed the answer to be *never.*

But that was before we saw the latest proposed decree from the federal government's Cost of Living Council. And now we're not so sure . . .

Because, under the Council's recently proposed price controls on medical care services, a physician could raise his prices—and then theoretically "prove" that his price increase was really a price decrease.

Apparently, there's a quirk in the equation the Council prescribed to test the legality of a medical price hike. Beginning in January, a physician was permitted to raise prices by an average of 4% a year, according to the Council's proposed ruling.

The Council's formula for computing a physician's "percentage aggregate weighted price increase" (%AWPI) appears in the box on this page. If you are mathematically inclined, you may enjoy finding for yourself the flaw in the Council's formula.

Easier still, let's test that formula with a purely hypothetical example.

During 1973, Dr. B. K. Sobranie (fictitious name) charged $10 to perform an unguisectomy (a slightly less fictitious procedure of minor surgery). He performed 217 unguisectomies during the year, and thus received $2,170 for that particular procedure.

His gross billing for last year—meaning the payments he received for all of the medical services he performed—amounted to $30,541.

Because his costs of business have been going up, Dr. Sobranie wishes to raise the price he charges for an unguisectomy to $10.40—an increase of 4%.

Would that price increase be within the Council's regulations? To find out, the doctor sets down the facts of the matter in accordance with the Council's AWPI formula.

The result: an apparent price decrease . . .

$$\%\text{AWPI} = \frac{\$10.00\text{-}\$10.40}{\$10.00} \times \frac{\$2{,}170}{\$30{,}541} \times 100 = \mathbf{-0.28\%}$$

The fact is, that formula—as published by the Cost of Living Council—will *always* result in a minus answer. Unless, of course, Dr. Sobraine were to reduce his prices. Then, the formula would indicate a price increase.

One can never be certain about the ways of government. Even so, we suspect that the topsy-turvy results the formula produces are not quite what the Council intended.

Oh, well. Nothing's perfect.

$$\%\text{AWPI} = \Sigma \frac{P_1 - P_2}{P_1} \times \frac{B_1}{B_2} \times 100$$

That's the Cost of Living Council's formula for computing a physician's "percentage aggregate weighted price increase" (or %AWPI, for short) for a given medical service.

The Council explains the equation's symbols thusly:

P_1 = the price lawfully in effect on the last day of the immediately preceding calendar year for a service or property.

P_2 = the highest price charged during the current calendar year for that service or property.

B_1 = the actual gross billings during the immediately preceding calendar year for that service or property.

B_2 = the total gross billings during the immediately preceding calendar year for all services or property.

Σ = the sum of.

Source: Federal Register (November 7, 1973)

(Reprinted from *AMA Update,* Vol. 3, No. 6, Dec., 1973)

mediclinic corporation
is pleased to
ANNOUNCE the OPENING
of the

chicago loop mediclinic



at 316 North Michigan Avenue

A Comprehensive Ambulatory Surgical Center

**Applications for
Surgical Privileges
now being accepted– Call (312) 782-0505**

Editorials

Medicine In Trouble

Medical societies should take a long look at their aims and purposes and bring them up to date before it is too late. For many decades, we have dedicated ourselves to give our patients the best possible medical care. The apathy among so many physicians is inherent upon this contention—"Let me alone—all I want to do is practice medicine." But now we are being told by the three demigods of our Federal government, Kennedy, Nader, and Meany, that we fall short of our goals and that they know how to do it better. On account of these verbal attacks, organized medicine goes on the defensive again—a method of fighting that never has won a battle.

In order to defend ourselves, we elect more committees, join hands with well-meaning local organizations, send a few of our leaders to Springfield and Washington, increase the budget (supposedly to add to the war chest), organize a few symposia, call a special county medical society meeting that only a dozen attend, and pass out awards for keeping scientific accomplishments in the press.

In my opinion, there are better ways to spend our money. Our budgets are at a record high and too many of our members see no improvement and complain that the threat of socialized medicine looms larger than ever.

Our tactics need to be overhauled. We must go on the offensive and fight fire with fire. It might be to our advantage to use the same tactics that have worked so well in labor unions and in politics to convince voters to send certain people to the Senate and the House of Represetnatives. Pomposity, aloofness, and the preaching of idealistic concepts is not going to work, despite the fact that we are in daily contact with voters. For example, a political analyst asked Senator Kennedy why he wanted to change the practice of medicine. Over national television, the senator said, "When an American mother calls a doctor, I want her to get one." That was all he said. Certainly not an earth-shaking comment, yet, right or wrong, the implications were obvious.

When our medical society argued on TV against committee action before admitting indigent patients into the hospital, ethics was stressed. It is too bad that no one had the presence of mind to say: "When your mother has a heart attack, must we wait for committee approval before she is admitted? By then, the dear lady would be dead."

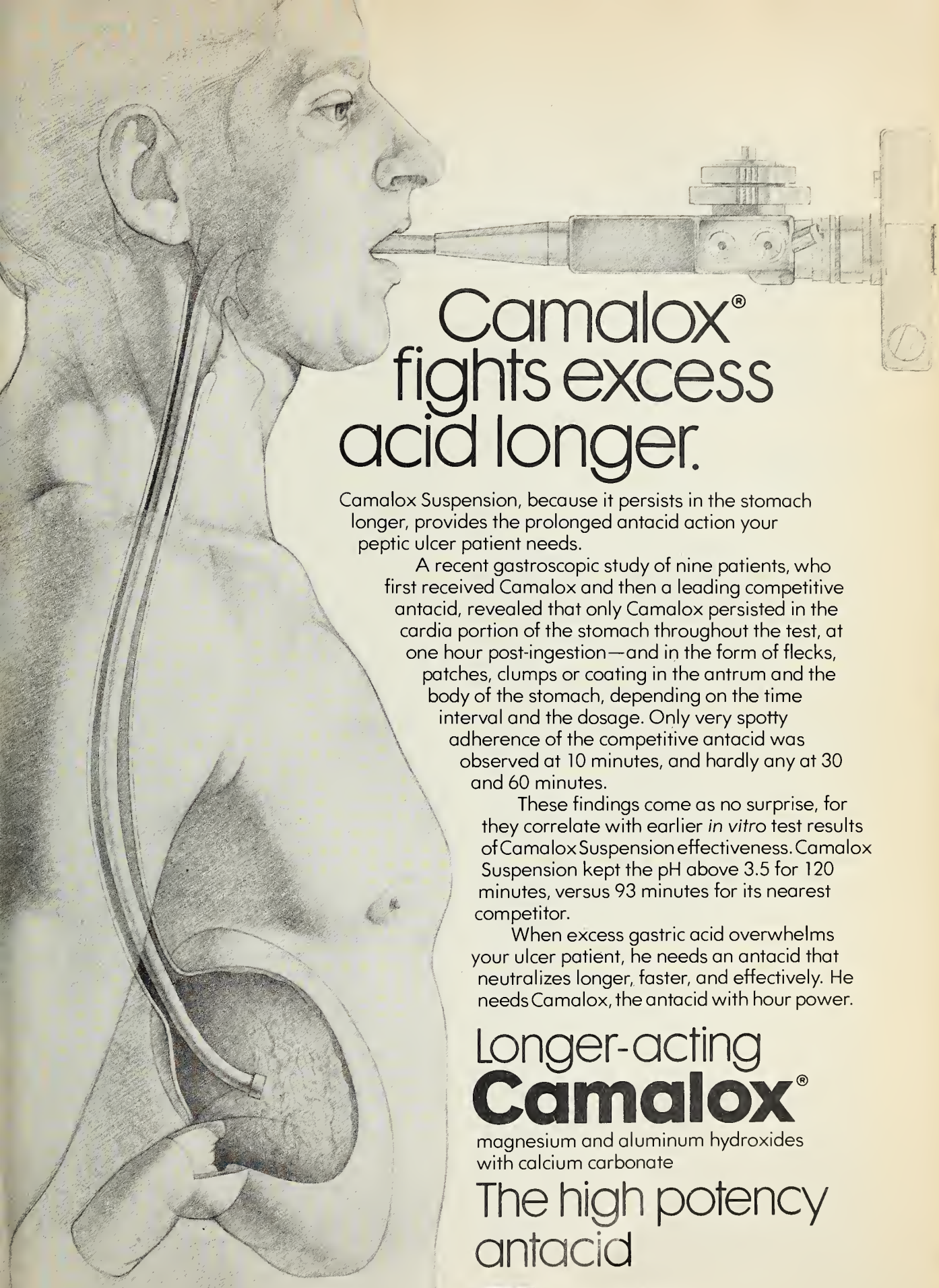
Why don't we tell the American people how many PSRO committees will be needed, how often they must meet, and the terrific expense. And all to save money because, supposedly, doctors don't know when a person is sick enough to be admitted and how long the patient should remain. Forget ethics—get down to the patient's level. Physicians who take advantage of the usual rules should be "kicked out."

We should instigate a national campaign about the flaws in government medicine as it is now practiced in Veterans, public health, municipal, county, and other hospitals. Patients will wait for hours and will be treated like sheep. Every honest physician will admit he has seen examples of this. And, it will be the labor leader or politician who will now get preferential treatment. Every physician could see 15% more patients were it not for the silly paperwork.

And, why not earmark some of our dues for bringing to the attention of our people the faults of other professionals? Watergate is little more than the pitting of one group of superlawyers against another. Many physicians continue to ask why the medical profession has been singled out to be checked by a PSRO. Should not the government also supervise lawyers and legislators? After all, the complexity of changing laws are as vital to their profession as medical advances are to the physician.

As Dr. J. G. Bohorfoush of Milledgeville, Ga., puts it: ". . . The collusion between judges and lawyers in probate is often scandalous. Stealing the livelihood from a widow is unethical and immoral, even if legal. The poor client with an uninterested lawyer being railroaded for a crime he did not commit, is pathetic." Not surprisingly, we hear very little from the American Bar Association that lawyers should be re-examined periodically. In other words, what is good for the goose is good for the gander. To attack this issue intelligently, we have to stop waving the white flag before starting the battle.

T. R. Van Dellen, M.D.
Editor



Camalox® fights excess acid longer.

Camalox Suspension, because it persists in the stomach longer, provides the prolonged antacid action your peptic ulcer patient needs.

A recent gastroscopic study of nine patients, who first received Camalox and then a leading competitive antacid, revealed that only Camalox persisted in the cardia portion of the stomach throughout the test, at one hour post-ingestion—and in the form of flecks, patches, clumps or coating in the antrum and the body of the stomach, depending on the time interval and the dosage. Only very spotty adherence of the competitive antacid was observed at 10 minutes, and hardly any at 30 and 60 minutes.

These findings come as no surprise, for they correlate with earlier *in vitro* test results of Camalox Suspension effectiveness. Camalox Suspension kept the pH above 3.5 for 120 minutes, versus 93 minutes for its nearest competitor.

When excess gastric acid overwhelms your ulcer patient, he needs an antacid that neutralizes longer, faster, and effectively. He needs Camalox, the antacid with hour power.

Longer-acting **Camalox®**

magnesium and aluminum hydroxides with calcium carbonate

The high potency antacid

ROR ER

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

Forearm Replantation

(Continued from page 316)

The patient recovered protective sensation in the hand, but has no independent function of the wrist or fingers. ◄

Acknowledgements

The authors wish to thank Drs. S. R. Kortebein, Otto Bouc, Gunar Graudins, John Medved and Jack Rohr for their contributions to the patient's care.

View Box

(Continued from page 333)

Diagnosis: Patients whose gallbladder cannot be visualized by means of oral cholecystography or intravenous cholangiography can be investigated by means of using a high dose of methylglucamine diatrizoate (Reno-M-Dip, Squibb®) in the form of a drip infusion study. This is combined with tomography of the gallbladder region as the drip injection is completed and takes a total of about 10 minutes. If the gallbladder wall is thicker than 1 mm. it is considered pathological. Most normal gallbladders will not visualize by this technique. It is postulated that the inflammed wall of the gallbladder permits the free diffusion of contrast material from the blood vessels into the tissues of the gallbladder wall in much the same way as bile and contrast medias diffuse through the lumen of the gallbladder into blood vessels in the presence of inflammation. Greater perfusion also occurs because of the increased vascularity of the thickened inflammed wall.

Thus, a technique is suggested which can be used in the presence of (a) jaundice, (b) abdominal pain and mass in the right upper quadrant, and (c) suspected acute cholecystitis in which the usual studies for gallbladder disease cannot be accomplished. If used as an emergency procedure, a diagnosis of cholecystopathy can be obtained within 15 minutes after completion of the study. An additional benefit is a routine I.V.P. film after the gallbladder area has been studied. ◄

Reference: S. Rabushka, L. Love, and R. Moncado, "Infusion Tomography of the Gallbladder," *Radiology*, Vol. 109, pp:549-552, Dec., 1973.

Parietal Cell Vagotomy

(Continued from page 340)

the gastrointestinal tract also diminishes the risk of infection after operation.

Parietal cell vagotomy is perhaps more difficult to accomplish from the technical standpoint. This procedure involves division of the vagus nerve supply along the lesser curvature of the stomach. (Figure 2) The operation begins with selection of the lower-most fibers at approximately the incisura angularis and then division of the nerve and blood supply upward along the lesser curvature. The nerve of Latarjet can be readily seen in the gastrohepatic ligament and must be carefully protected. The division of fibers continues across the esophagogastric junction to make certain that all fibers to the parietal cell portion of the stomach are interrupted, both anteriorly and posteriorly.

The results that are being reported in the literature are encouraging. Postoperative complications are few and gastric retention is absent, unless there has been some pre-existing stasis. Parietal cell vagotomy is not suitable for the treatment of duodenal ulcer with obstruction, unless a drainage procedure is performed.

Uncertainties remain as with other new procedures. A longer period of follow-up will be required to determine whether the reduction of gastric acidity persists after selective vagotomy of the parietal cells. A larger number of patients must be subjected to this operation to determine the incidence of incomplete vagotomy. In general, parietal cell vagotomy has been employed in the treatment of duodenal ulcer. One group in Great Britain has initiated a series in which this operation is being used in the treatment of gastric ulcer and their preliminary report has been encouraging. ◄

References

1. Dragstedt, L. R. and Owens, F. M.: *Proc. Soc. Exp. Biol. & Med.* 53:152, 1948
2. Franksson, C.: *Acta Chir. Scand.* 96:409, 1948.
3. Latarjet, A.: *Bult. Acad. Med.* 87:681, 1922.

Hemofiltration For Schistosomiasis Japonicum

(Continued from page 321)

logic changes there. If such a shunting procedure should therefore become necessary in the patient with hepato-splenic schistosomiasis, it is desirable to reduce or remove the worm burden by the hemofiltration technique prior to the procedure.

To date, the patient presented here has had no further bleeding episodes, and on contrast roentgenograms of the esophagus, the previously demonstrated varices have disappeared. Although his portal venous pressure has not been measured directly following hemofiltration, his course and other postoperative studies are presumptive evidence that it has been reduced. The exact mechanism for this is unclear. Despite the absence of any controlled studies to document this phenomenon, Goldsmith[10] has expressed the opinion, based on empiric observations, that the reduction of the worm burden by hemofiltration may result in a reversal of the pre-sinusoidal portal hypertension. It is hoped that the patient presented here will not require porto-systemic shunting.

Summary

A case of hepato-splenic schistosomiasis occurring in a Laotian graduate student in Illinois is presented. The presenting feature was bleeding esophageal varices which spontaneously ceased on conservative management. His subsequent treatment with portal-venous hemofiltration is described in detail. Human schistosomiasis and current modes of therapy are reviewed. ◄

References

1. World Health Organization: "Malaria Eradication in 1965." *W.H.O. Chron.* 20:296, 1966.
2. Kean, B. H. and Goldsmith, E. I.: "Schistosomiasis Japonica." *Am. Journal Med.* 47:546-552, 1969.
3. Goldsmith, E. I.; Carvalko Luz, F. F.; Prata, A., and Kean, B. H.: "Surgical Recovery of Schistosomes from the Portal Blood." *JAMA.* 199:83-88, 1967.
4. Most, H.: "Drug Therapy: Common Parasitic Infections in Man." *NEJM.* 287:698-702, 1972.
5. Jordan, J. and Webbe, G.: Human Schistosomiasis. W. Heinemann Med. Books Ltd., London, 1969.
6. Edington, G. M. and Gilles, H. M.: Pathology in the Topics. E. Arnold Publishers, Ltd., London, 1969.
7. Aufes, A. H.; Schaffuer, F.; Rosenthal, W. S., and Herman, B. E.: Portal Venous Pressure in "Pipestem" Fibrosis of the Liver Due to Schistosomiasis." *Am. Journal Med.* 807-810, 1959.
8. Goldsmith, E. I. and Kean, B. H.: "Extracorporeal Hemofiltration in Urinary-Schistosomiasis." *Am. Journal Trop. Med. and Hygiene* 18:382-386, 1969.
9. Kessler, R. E.; Amadeo, J. H.; Tice, D. A., and Zimmon, D. S.: "Filtration of Schistosomes in Unanesthetized Man." *JAMA.* 214:519-524, 1970.
10. Goldsmith, E. I.: Personal communication, August 1972.

President's Page

(Continued from page 300)

to curb the unethical practices of some pharmacists. The law has the same effect today; ethical pharmacists are in no way restricted. A physician can delegate product selection to a pharmacist, prescribe generically, prescribe by brand or equivalent, or include on the prescription a statement permitting substitution.

Pharmacists are trained in pharmacology; they are not trained to treat patients. Treatment involves knowledge of the person both medically and psychologically as well as knowledge about which drugs are most effective for that patient.

The pharmacist also is not equipped to determine therapeutic equivalence which is based upon clinical as well as manufacturer information. How can his judgment be equated to that of a physician who is informed in both areas?

Only physicians are equipped by training and experience to determine what drug is appropriate. We have an obligation to prescribe, when appropriate, the less expensive medication. However, supporters of the legislation to repeal the anti-substitution law would have us make medical decisions based upon dollar signs in all cases.

The latest chapter of the anti-substitution story still is being written. The ending can be influenced by the physicians of Illinois. We must tell our story to both the legislators and the public.

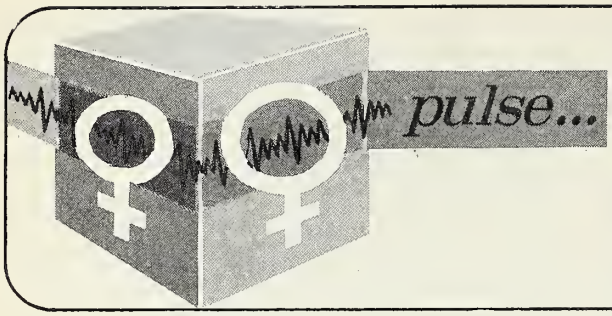
EKG of the Month

(Continued from page 352)

Answers: *1 B, C 2. E*

The ECG is a rhythm strip of simultaneously taken leads I, II and III. Bigeminy is present in that long R-R cycles are alternating with short R-R cycles. It can be seen, especially in line 3, that the T waves of beats 2, 4, 6, and 8 have a notch not present in the other T waves. This is a non-conducted premature atrial beat. Its costour is different from the P wave contour of the sinus beats. When this lady initially presented, she had a non-conducted atrial premature beat alternating with a conducted sinus beat. The sinus conducted beats resulted in an effective ventricular rate of about 40 per minute and symptoms. Quinidine reduced the incidence of non-conducted premature atrial beats from every other beat to every third atrial beat.

The underlying cause of premature atrial beats is the pathology of the heart in question, e.g. rheumatic heart disease, coronary artery disease, etc. Non-conducted or blocked premature atrial beats may simulate heart block. An increase in quinidine dosage to further depress the atrial premature beats resulted in quinidine toxicity. ◄



pulse... of the doctor's wife

Mrs. Harold Keegan, *Editor*

Message From . . .

Mrs. Thomas Glatter WA/ISMS President For 1974-75

It is a privilege, but an awesome responsibility, to serve as your President. We have much work to do—TOGETHER—you and I!

What is State? I have been asked that question many times over the years. State, or Woman's Auxiliary to the Illinois State Medical Society, is the "parent" of your County Medical Auxiliary. It's purpose is to guide the counties in achieving these objectives of our organization, which are:

1. To assist the Illinois State Medical Society in its program for the advancement of medicine, public health and medical education.
2. To aid in securing legislation indicated in the pursuance of these ends.
3. To act as liaison between the medical profession and the general public by cooperating with other organizations, both in Illinois and elsewhere, upon recommendation of the Advisory Committee of ISMS.
4. To coordinate and advise concerning the activities of the constituent medical auxiliaries.
5. To cultivate friendly relations and promote mutual understanding among physicians' families.
6. To contribute to the Benevolence Fund.

We have a great team leading our State organization this year. In addition to myself, there are:

Mrs. Eugene Vickery, *President-Elect*
Mrs. Ralph Davis, *VP/Membership*
Mrs. Edward Szewczyk, *VP/Com. Health*
Mrs. Earl Klaren, *VP/Program*
Mrs. William Hodges, *Treasurer*
Mrs. L. P. Johnson, *Corresponding Secy.*
Mrs. Leo Kempton, *Rec. Secy.*
Mrs. Robert Hartman, *Director*
Mrs. Paul David, *Director*
Mrs. Harlan Failor, *Director*

My "Happiness is"—serving you—as your president.

Mrs. Thomas Glatter,
WA/ISMS President

"Health Education is the Key"

Members of the Woman's Auxiliary, Illinois State Medical Society and civic organization representatives attended the one-day Health Education Symposium held February 28, 1974, at the LaSalle Hotel, Chicago. The symposium, co-sponsored by ISMS and the Woman's Auxiliary to ISMS, carried out the theme, "Health Education is the Key" through the various speakers, panel discussion and audience participation.



Contributing to the successful symposium were: (left to right (Mrs. Wendell F. Roller, Symposium Co-Chairman' Robert Kaplan, Ph.D., Keynote Speaker' Theodore R. VanDellen, M.D., *Illinois Medical Journal,* Editor; and Mrs. Howard Liljestrand, WA/AMA President-Elect.



The participants gathered information at the display center.



Registration was a busy spot early in the day.



There to discuss "In Illinois What Can We Do?" were: (left to right) William M. Lees, M.D., Chiarman, ISMS Board of Trustees; William Carlyon, Ph.D., Department of Health Education, AMA; Fredric Lake, M.D., ISMS President; and William Robinson, M.P.H., Chicago Board of Health.



Robert Kaplan, Ph.D., keynote speaker, told the audience "Why Health Education."



The audience listened, took notes and contributed much to the symposium.

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
360 No. Michigan Ave. • Chicago, IL 60601 • (312) 782-1654

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

MAY

Anesthesiology

MAC XI—11th MIDWEST ANESTHESIOLOGY CONFERENCE: ANESTHESIA & THE NEUROMUSCULAR SYSTEM
For: Physicians & Surgeons interastad in anasthasia. May 23-25, 1974 (NOTE CORRECTED DATES), Sharaton-Chicago Hotal, Chicago. **Hrs. of Instr.:** 18. **CME Credit:** AMA Cetagory 1. **Fee:** $25 (nona for ISA Mambars, House-Steff, Studants). **Sponsor, contact:** Ill. Society of Anasthasiologists, Micheal Raasa Mad. Cntr., 29th & Ellis Ave., Chicago, IL 60616; (312) 791-2544, ext. 29.

Cardiology

EXERCISE TESTING IN CLINICAL PRACTICE, 1974
For: Internists, Cardiologists, Family Physicians. Aftarnoon symposium, Mey 1, 1974, Northwestern Mam. Hosp.—Passevant Pavilion, Chicago. **Hrs. of Instr.:** 4. **CME Credit:** AMA Cetagory 1. **Reg. Deedline:** April 19, 1974. **Sponsor:** Chicago Heart Assn.; Northwastern Univ. **Contact:** Ms. Graca De Santis, Chicago Heart Assn., 22 W. Madison St., Suite 506, Chicago, IL 60602.

ELECTROCARDIOLOGY REVIEW
For: Family Physicians, Intarnists, Padietricians. Symposium, May 1-2, 1974, Indianapolis. **Hrs. of Instr.:** 12. **CME Credit:** AAFP, AMA Cetegory 1. **Fee:** $50. **Sponsor, contect:** Mr. John Roscoa, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

CARDIOLOGY TODAY—RECENT ADVANCES IN TREATMENT & DIAGNOSIS
For: All physicians. Mey 6-9, 1974, Iowa City. **Hrs. of Instr.:** 32. **CME Credit:** AMA Category 1. **Fee:** $200. **Sponsor, contect:** Univ. of Iowa Coll. of Med., Nawton Rd., Iowa City, Ia. 52242.

INTERMEDIATE ELECTROCARDIOGRAPHY
For: All physicians. Mey 9-10, 1974, Chicago. **Hrs. of Instr.:** 14. **CME Credit:** AMA Cetagory 1. **Fee:** $75. **Reg. Limit:** 35. **Sponsor, contect:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

MILD & MODERATE HYPERTENSION
For: Intarnists & Osteopaths. Symposium, Mey 23-24, 1974, Stouffer's Riverfront Inn, St. Louis. **Hrs. of Instr.:** 12. **CME Credit:** AAFP. **Fee:** $30 (physicians); $10 (house-staff & paramad.) **Reg. Deadline:** May 10. **Sponsor, contect:** Washington Univ. Sch. of Med., Ofc. of CME, 660 S. Euclid Ava., St. Louis, 63110.

Recent CME Accreditations

The ISMS Committee on CME Accreditations has recently approved the CME programs of these institutions:

Community Hospital, Geneva

DuPage County Medical Society

Dermatology

SPECIALTY REVIEW COURSE IN DERMATOLOGY
For: Spacialists. 5-day course, May 6-10, 1974, Chicago. **Hrs. of Instr.:** 35. **CME Credit:** AMA Category 1. **Fee:** $130. **Reg. Limit:** 75. **Sponsor, contact:** Cook County Grad. Sch. of Mad., 707 S. Wood St., Chicago, Ill. 60612.

Emergency Care

18TH ANNUAL POSTGRADUATE COURSE ON FRACTURES & OTHER TRAUMA
For: Orthopaadic Surgaons, Genaral Surgaons, Ganeral Physicians. May 8-11, 1974, Sheraton-Chicago Hotal, Chicago. **Hrs. of Instr.:** 28. **CME Credit:** AAFP, AMA Catagory 1. **Fee:** $140. **Sponsor:** Chicago Comm. on Trauma, Amar. Coll. of Surgaons. **Contact:** Ralph T. Lidge, M.D., c/o Amer. Coll. Surgaons, 55 E. Eria St., Chicago, IL 60611.

EMERGENCY TRAUMA SEMINAR
For: Family Physicians, Internists, Occupational Med. Symposium, May 9, 1974, Home Hospital, Lafayatta. **Hrs. of Instr.:** 6. **CME Credit:** AAFP, AMA Catagory 1. **Fee:** $35. **Sponsor, contact:** Mr. John Roscoe, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

HOSPITAL PROGRAM—MUSCULO-SKELETAL TRAUMA
For: All physicians. Monthly clinical program, May 9, 1974, 8 p.m., Childrens Mem. Hospital, Chicago. **Hrs. of Instr.:** 2. **CME Credit:** AMA Catagory 1. **Sponsor:** Chicago Comm. on Traume, Amar. Coll. of Surgaons. **Contact:** Howard W. Schneider, M.D., 238 W. 154th St., Harvey, Ill. 60426.

General Interest

SPRING CLINICAL CONFERENCE
For: All physiciens. 3-dey conference, May 9-11, 1974, Univ. of Missouri Mad. Center, Columbia. **Hrs. of Instr.:** 18. **CME Credit:** AMA Catagory 1. **Sponsor, contact:** Univ. of Missouri-Columbia Sch. of Mad., 807 Stedium Blvd., Columbie, Mo. 65201.

THERAPEUTICS
For: Family Physicians. May 8-9, 1974, Towsley Cantar for CME, Ann Arbor, Mich. **Hrs. of Instr.:** 14. **CME Credit:** AMA Category 1. **Fee:** $75. **Sponsor, contact:** Univ. of Michigan Mad. Cntr., Towslay Cntr. for CME, Ann Arbor, MI 48104.

General Medicine

GENERAL MEDICINE LECTURE SERIES
For: All physicians. Lacture series, May 14, 28, 1974, St. Mary of Nazareth Hospitel, Chicago. **Hrs. of Instr.:** 2 aach. **CME Credit:** AAFP. **Sponsor, contact:** A. R. Sapienza, M.D., St. Mery of Nazareth Hosp. Cntr., 1120 N. Leavitt St., Chicago, IL 60622.

Immunobiology

CLINICAL IMMUNOBIOLOGY FOR PRACTICING PHYSICIANS & SURGEONS
For: Femily Physicians, Surgaons, Pethologists. Workshops & discussion, May 10-11, 1974, Pfister Hotal, Milweukaa, Wis. **Hrs. of Instr.:** 14. **CME Credit:** AAFP. **Fee:** $125. **Reg. Limit:** 200. **Sponsor, contect:** Anna T. Finnegan, Ofc. of Cont. Educ., Tha Madical Collaga of Wis., 561 N. 15th St., Milweukee 53233.

Internal Medicine

DIABETES
For: All physiciens. Seminer, lecture, Mey 10, 1974, 10 a.m., Amaricen Hospital; May 10, 6 p.m., Lincolnwood Hyett House; Mey 11, 10 e.m., Bethasda Hospital, Chicago. **Hrs. of Instr.:** 5. **CME Credit:** AAFP, AMA Category 1. **Fee:** $10 (non-staff, for dinner). **Reg. Deadline:** Mey 6. **Sponsor:** FAB³-CME. **Contect:** Mr. J. Perdea, American Hosp., 850 W. Irving Pk. Rd., Chicago, Ill. 60613, (312) LA 5-6780.

ADVANCES IN INTERNAL MEDICINE
For: Internists. May 20-23, 1974, Towsley Canter for CME, Ann Arbor, Mich. **Hrs. of Instr.:** 28. **CME Cradit:** AMA Category 1. **Fee:** $130. **Sponsor, contact:** Univ. of Michigan Mad. Cntr., Towslay Cntr. for CME, Ann Arbor, MI 48104.

DIABETES SYMPOSIUM
For: Intarnists, Family Physicians. Symposium, May 29, 1974, Holiday Inn, Merrillvilla, Ind. **Hrs. of Instr.:** 6. **CME Cradit:** AAFP, AMA Catagory 1. **Fee:** $35. **Sponsor, contact:** Mr. John Roscoa, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Obstetrics/Gynecology

COMMON GENETIC DISEASES
For: All physicians. May 6-10, 1974, Chicago. **Hrs. of Instr.:** 35. **CME Credit:** AMA Category 1. **Fee:** $200 **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

SPECIALTY REVIEW COURSE IN OB/GYN
For: Specialists. May 13-24, 1974, Chicago. **Hrs. of Instr.:** 86. **CME Credit:** AMA Catagory 1. **Fee:** $300. **Reg. Limit:** 85. **Sponsor, contact:** Cook County Grad. Sch. of Mad., 707 S. Wood St., Chicago, Ill. 60612.

OB-GYN ROUNDS
May 19-20, 1974, Univ. of Missouri Mad. Center, Columbia, Mo. **Hrs. of Instr.:** 12. **CME Credit:** AMA Catagory 1. **Sponsor, contact:** Univ. of Missouri-Columbia Sch. of Med., 807 Stadium Blvd., Columbia, Mo. 65201.

FETAL & PERINATAL MEDICINE
For: Ob-Gyn, Family Physicians. Symposium, May 21-22, 1974, Indianapolis. **Hrs. of Instr.:** 12. **CME Credit:** AAFP, AMA Category 1. **Fee:** $50. **Sponsor, contact:** Mr. John Roscoa, Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, Ind. 46202.

Ophthalmology

GLAUCOMA CONFERENCE
For: Ophthalmologists. May 1-3, 1974, Towslay Center for CME, Ann Arbor, Mich. **Hrs. of Instr.:** 17. **CME Credit:** AMA Cetagory 1. **Fee:** $110. **Sponsor, contact:** Univ. of Michigan Med. Cntr., Towsley Cntr. for CME, Ann Arbor, MI 48104.

CLINICAL ECHO-OPHTHALMOLOGY COURSE
For: Specialists. May 1-3, 1974, Univ. of Iowa Mem. Union, Iowa City. **CME Credit:** AMA Category 1. **Fee:** $150. **Sponsor, contact:** Univ. of Iowa Coll. of Mad., Newton Rd., Iowa City, IA 52242.

Your Ideas, Please

If there's a continuing education course or other learning service not now available that you'd find helpful—please write us about it, or jot a note on your prescription pad. Periodically, we'll tabulate those ideas and transmit the information to appropriate CME sources.

Regretfully, available staff does not permit responses to individual suggestions.

Abstracts of Board Actions

(Continued from page 367)

History of Medicine

The Board indicated a definite desire and commitment to publish HISTORY OF MEDICINE IN ILLINOIS, Volume III, providing a major portion of the cost can be obtained through grants. It authorized the Publications Committee to solicit such grants actively as well as developing an organizational plan for material gathering and designating responsibilities. Referred to the Finance Committee was a request that the Board determine the extent of ISMS financial participation in the project.

Health Screening

The following resolution on health screening was approved for presentation to the House of Delegates:

"Resolved, that health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician and interpretation of the appropriateness and reliability of various screening procedures used."

Hospital Staff Assessments

The Policy Committee was directed to prepare a resolution clarifying ISMS policy on compulsory assessment of hospital medical staff members for consideration by the ISMS House of Delegates in April, 1974.

Dues Payment System Changed

The following dues rebate plan has been offered to county medical societies:

To any county society which qualifies under the AMA County Membership Support Program, ISMS will rebate the unallocated portion of all dues received in excess of the gross dues received from members in that county during 1973. Counties wishing to participate need only send ISMS a copy of their agreement with the AMA and a copy of the report required by AMA. This program will apply only to those county societies which recruit a minimum of 10 additional members over 1973.

As an incentive to state societies to report membership and remit dues before April 1, the AMA has offered to pay state societies one-half of one percent above the prime rate of interest on dues received at AMA headquarters by April 1. ISMS will share one-half of the amount received from the AMA with those county societies which promptly forward 1974 dues dollars to ISMS headquarters.

The Board also will ask the House of Delegates to move up the dues delinquency date to February 1 to avoid any possible legal repercussions to component medical societies, ISMS or the AMA resulting from withholding of IMPAC and AMPAC funds. It was reported that ISMS has a larger number of sustaining members of AMPAC than any other state.

The Board also approved a recommendation of the Advisory Committee to Medical Students and Physicians in Training that a $5 one-time dues payment be instituted for student members rather than annual dues. The recommendation will be presented to the House of Delegates.

Appointments and Travel Authorizations

Wayne Leimbach, M.D., Aurora, was recommended for appointment to the Illinois Department of Public Health's Clinical Laboratory and Blood Bank Advisory Board and William M. Lees, M.D., for reappointment to the department's Hospital Licensing Board.

Ronald Mack, M.D., Riverside, will represent ISMS on the Council on Smoking and Health; Paul Sunderland, M.D., Gibson City, and Jacob E. Reisch, M.D., Springfield, at the annual meeting of the U.S. Chamber of Commerce, April 28-30, in Washington, D.C.; Willard Scrivner, M.D., Belleville, at the AMA Conference on Health Care of the Poor, March 22-23, in Washington, D.C.; Donald Stehr, M.D., Havana, at the AMA conference on Rural Health, April 25, in Detroit; Bertram Moss, M.D., Chicago, at the AMA National Conference on the Aging Driver, May 2-4, in Washington, D.C., and Dr. Sunderland at the Feb. 23-24 meeting of the AMA Committee on Private Practice in New Orleans.

The Board also nominated the following to serve on the Comprehensive Health Planning Technical Input Committee:

Drs. Samuel Conlinger, Howard Burkhead, James Sutherland, Frank J. Jirka, Jr., David Helberg, Richard Buenger, Lawrence Breslow, A. R. Eveloff, E. B. Sylvester, Eugene Johnson, Donald Hanscom, Charles Jannings, Earl Frederick, Fred A. Tworoger, Dean Bordeaux, Lawrence Hirsch, Robert D. Hart and Eugene T. Leonard.

Marshall Falk, M.D., was designated a "liaison" to the Illinois Mental Health Code Revision Commission.

Endorsement of AMA Candidates

Joseph R. O'Donnell, M.D., was endorsed for appointment to the AMA's Committee on Health Care Financing and William M. Lees, M.D., for election to the AMA Council on Medical Education.

Medical Examining Committee

The names of Drs. Basilio S. Bolumen, Theodore Bartlett and Antonio Santos will be forwarded to the Department of Registration and Education as ISMS nominees for the Medical Examining Committee. The nominees are Latin American physicians which, it is understood, are being considered for a position on the committee.

Foundations For Medical Care

Drs. Allan Goslin, Frederick Weiss and A. Edward Livingston, were re-nominated to the Board of Directors of the Illinois Foundation for Medical Care. In a related action, the Board denied a request from the Chicago Foundation for Medical Care for endorsement as the official body to implement peer review in Cook County. CFMC will be informed that the society is unable to address itself to the issue until the legal status of foundations in the PSRO program has been clarified.

Pre-Admission Certification

The draft of a letter to the Social Security Administration, in which ISMS protests the proposed regulations on pre-admission certification of Medicare and Medicaid hospital admission, was approved by the Board.

Committee on Quackery

A new Committee on Quackery was created to function as an educational and monitoring group, to initiate action against cultist activities, and to provide expert testimony on proposed legislation. Appointed to the committee were: Drs. Richard Treanor, Arlington Heights; Alfred Faber, Glenview; Charles Daisy, Greenville; William M. Lees, Lincolnwood, and Paul Mahon, Robert Prentice and Philip Hagerty of Springfield.

Task Force on EPSDT

At the request of the AMA, the Board created a Task Force on Early Periodic Screening, Detection and Treatment consisting of: Dr. Lawrence Hirsch, Chicago, Chairman, with Drs. Robert Hartman, Jacksonville; Robert Kark,

With financial assistance from AMA, the Task Force held a statewide educational conference on EPSDT (MEDICHEK) January 25 and recommended that the area of Will-Grundy and Kankakee counties be designated as the site for an EPSDT pilot program. In a related action, the Board agreed to ask the Illinois Department of Public Aid to include nursery records in every child's MEDICHEK file in order to aid the physician in making a physical examination. This action was taken pending advice of legal counsel.

Governmental Health Program Reimbursement

The Board directed legal counsel to investigate the legality of making the Illinois Department of Public Aid Medical Advisory Committee a formal body of ISMS.

In addition, the Board will request IDPA to consider using AMA's standard claim form, with appropriate changes. The Board also will ask IDPA and the Illinois Department of Mental Health to consider using HASP to certify in-hospital psychiatric lengths of stay and to consider relaxing the $300 maximum per patient per year for psychiatric treatment. The two departments will be asked to meet concurrently with the ISMS Council on Mental Health to discuss these recommendations.

IDPA Policy on Surgical Procedures

ISMS will request the Illinois Department of Public Aid Medical Advisory Committee to review IDPA's payment policy for jejunioleal by-pass surgery and evaluate the benefits, patient risks, complications and hazards of this surgical procedure, as well as proper selection of patients by appropriate sources throughout the country. In addition, the Eye Health Committee was directed to study a new procedure for cataract surgery employing phaco emulsification to determine its medical validity and recommended levels of payment so that ISMS might ask IDPA to provide reimbursement under Medicaid.

Physical Therapy

Because of continuing reports that unauthorized personnel are performing physical therapy, the Board will urge members to notify ISMS of specific instances of such abuse. The information will be forwarded to the Department of Registration and Education. Guidelines for Prescribing Physical Therapy, developed in 1969, will be republished in the *Illinois Medical Journal.*

Relative Value Study

The Relative Value Study Committee recommendations for producing a new Illinois RVS were approved in principle and will be submitted to the 1974 House of Delegates for its consideration.

Proposed Aetna Letter

Aetna Insurance Company has revised its letter to patients, but it still implies the company's reimbursement is payment in full. ISMS will again urge Aetna to tell patients the payment to the physician reflects only the amount Aetna considers its liability under the patient's policy. Any difference between the amount paid and the MD's fee becomes the responsibility of the patient.

Payment for Utilization Review Committees

A resolution approving physician payment for service on hospital utilization review committees was endorsed by the Board and will be submitted to the House of Delegates; this resolution will be forwarded to the AMA.

Public Relations

At the request of the Council on Public Relations and Membership Services, the Board agreed to set definitive policies and guidelines to aid the public relations staff in preparing news releases, scheduling speakers and carrying out other activities which may reflect ISMS positions toward chiropractic, acupuncture, the state's Emergency Medical Services program and other controversial issues. It was also agreed that guidelines, priorities and responsibilities of staff be established by the Board for conducting membership campaigns in all counties except Cook.

The Board also agreed to appoint the ISMS president-elect to the Council on Public Relations as a matter of regular policy.

Emergency Referral Service

A proposal for a 24-hour Emergency Referral Service, prepared by the Council on Public Relations and the Council for Community Services in Metropolitan Chicago, was also approved. The service would not duplicate the physician referral services operated by the Chicago Medical Society, but would consist of a 24-hour "hotline" which would provide medical and health information to callers throughout the Chicago metropolitan area. The possibility of obtaining grants to support the service is now being explored.

Fifty-Year Club Luncheon

The Board rejected a recommendation of the Council on Public Relations that the annual Fifty-Year Club Luncheon be discontinued. The council suggested that the money spent on this function could be spent to better advantage. However, it was pointed out that the luncheon usually draws more than 100 physicians who look forward to the event and that it was too late to consider cancelling it this year. The Board agreed to provide the necessary funds.

Ambulatory Surgical Treatment Centers

The Board approved the following recommendations of the Council on Affiliate Societies with respect to licensing ambulatory surgical treatment centers (ASTC):

That ASTC ownership and staff privileges be broadened to include any physician licensed to practice medicine in all its branches and is qualified to perform surgical or medical procedures based on his training, experience and demonstrated ability; that licensed ASTCs should be required to appoint a credentials committee from its medical staff to establish privileges for staff physicians; that ASTC staff members need only have admitting privileges in a nearby hospital, thus eliminating the need for an ASTC written agreement with a hospital; and that ASTC regulations should be amended to require the necessary equipment and personnel for cardiac pulmonary resuscitation. These recommendations are to be forwarded to the Illinois Department of Public Health for consideration by the ASTC licensing board.

FDA Seizure of Medical Devices

On advice of the Medical-Legal Council, the Board refused to endorse a resolution proposed by Chicago Attorney Mrs. Esther Kegan, which protested the power of the Food and Drug Administration to seize medical devices. The Board was informed that federal legislation is currently pending in this matter.

Medical Legal

The Board authorized legal counsel to review and comment on county medical society liability matters involving possible litigation on ethical relations issues. In addition, counsel is to review the matter of non-incorporated county societies being jointly and severally liable in cases brought against the county society.

Direct Membership for Interns and Residents

ISMS will recommend that the AMA not accept interns and residents as direct members in those states where membership is provided through their component societies. It will also recommend that the resident and intern Business Section of the AMA be allowed representation in the House of Delegates as specialty societies. In a related action, the Board agreed to notify the AMA that ISMS opposes direct representation of specialty societies in the House of Delegates. ◄

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program. This is a free service to all physicians.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

ALBION: Population 2,000. Family Physician for community located in Southern Illinois in Edwards County with doctor-patient ratio of 1:3500. Located one hour from metropolitan area. Office space available. Financial assistance available. Contact: Don Broster or Jerry Wiseman, Citizens National Bank of Albion, 618-445-2344. (4)

AMBOY: Population 2,200. Shopping area—approximately 6000. Located 100 miles west of Chicago; just south of the East-West Tollway. Office space available. Year 'round recreation. Complete downtown shopping areas. Contact: Larry G. Hawes, 220 East Main St., Amboy, 61310, 815-857-3625. (4)

BERWYN: 5 Emergency Room Physicians needed. 442-bed hospital; suburban Chicago. Patient diagnosis, management and disposition. University of Illinois Abraham Lincoln School of Medicine appointment available. 3 years emergency experience or emergency medicine residency (other residencies considered). Contact: Kenneth Kessel, M.D., E.R. Director, MacNeal Memorial Hospital, Berwyn, 60402, 312-787-300. (4)

BUSHNELL: Doctors! ! ! The pot of gold at the end of the rainbow is at Bushnell. Contact: Jack Gordon, 462 East Main St., Bushnell; call collect 309-733-3141. (6)

CARBONDALE: 30 man multispecialty group. University community with medical school. Mild climate with recreational facilities. Drawing area of 500,000. Contact: Dr. Donald Darling, Carbondale Clinic, Carbondale, 62901, 618-549-5311. (4)

CARLINVILLE: City population 6000. County seat serving 25,000. Six physicians in city. 68-bed general hospital. Midway between Springfield, Ill. and St. Louis—one hour drive. Financial assistance available. Contact: Jim Rives, P.O. Box 35, Carlinville, 62626, 217-854-3141. (4)

CARROLLTON: Ample excellent opportunities in Greene County for Family Physician. Group practice being set up in new office accommodating 4-5 M.D.s next to hospital. For further information, contact: Dr. Caselton or Dr. Chung or Roy Shoemaker in Carrollton, 62016, 217-942-6946. (4)

CARTHAGE: County seat of Hancock County; population 24,000. Need Family Practitioners, Radiologist, Pathologist, Internist. Opportunity for solo or group practice. Minimum guaranty offered by 130-bed hospital and nursing home. State University nearby. Contact: Harold A. Dietz, Administrator, Memorial Hospital, Carthage, 62321, 217-357-3131. (4)

CHAMPAIGN: Private hospital expanding and building new 110 bed facility. We are seeking a General Surgeon, Internist and Family Practitioner. Minimum guarantee offered. Contact: Donald L. Francis, Executive Director, Cole Hospital, Inc., 809 W. Church Street, Champaign, 61820; (217) 356-3788. (8)

CHENOA: Rural area, 100 miles south of Chicago on I-55. Looking for one or two physicians to do family practice. Hospital facilities nearby. Financial assistance and office space can be arranged. Contact: R. J. Walker, National Bank of Chenoa, Chenoa, 61726, 815-945-2311. (4)

CHICAGO: Private young multispecialty group seeks General Practitioners or Medical Specialist. University affiliation available. Spanish speaking M.D. welcomed. Contact: Dr. Finley W. Brown or Dr. Gonzalo Ruiz, 3109 W. Armitage, Chicago, 60647, 312-276-8811. (7)

CHICAGO: Young multispecialty group with 4 locations. 24 physicians at present. Need Family Physicians or General Internists. Hospital appointments assured. Financial reward comensurate with effort. Opportunity to grow with group. Contact: Dr. Arthur Kunis, 3157 W. Lawrence Ave., Chicago, 60625, 312-478-1939. (6)

CHICAGO: Privately owned clinic, south side. 44-hour week. No night work. Contact: Robert C. Parro, Professional Medical Center, Inc., 104 E. 51st St., Chicago, 60615, 312-268-3400. (4)

CLINTON COUNTY: Population 28,400. 35 miles east of St. Louis. General Practitioner, Pediatrician, Internist. New 104 bed modern, progressive hospital. Office facilities and financial assistance available. Excellent school and friendly people. Beautiful Carlyle lake minutes away. Contact: John Rehkemper, RR 2, Highland, 618-654-3527. (6)

CHRISTOPHER: Area population 20,000. Office facilities for two family physicians. New hospital and nursing home being built in Christopher. Financial assistance available. New subdivisions, excellent schools, churches. Heart of five new lakes and recreation areas. Near Southern Illinois University. Contact: Jeff Troutt, Box 5, Christopher 62822, 618-724-2928. (4)

COLFAX: Population 978. One physician at present who desires another doctor to occupy remaining portion of new clinic. Twenty-five miles from Bloomington. Financial assistance available and housing available. Recreational facilities nearby. Contact: Don Wilber, Colfax, 309-723-4671, or Michael Payne, 212 East Washington Street, Bloomington, 61701, 309-829-6344. (6)

DIXON: Internist-General Surgeon—board certified/board eligible. Recently established multi-specialty clinic with close affiliation to a 200 bed hospital offers opportunities to build a large practice in both of these specialties. $40,000 a year guarantee plus fringe benefits and opportunities that are quite challenging. Progressive rural community offers a unique family oriented environment. No traffic problems, clean air, and excellent recreation areas combine to provide the "good life." Only 1 hr. 15 min. from Chicago allows easy access for exposure to academic medicine. Phone collect—John Tatum, Administrator, Medical Arts Clinic, Dixon, 61021, 815-288-5531. (4)

Obituaries

*Allegretti, J. E., River Forest, died March 4, at the age of 73. He was a graduate from Rush Medical College in 1924.

*Bianco, Peter B., Peoria, died Februarv 21, at the age of 66. He was a 1939 graduate of Loyola University Stritch School of Medicine.

**Burket, Walter C., Evanston, died February 20, at the age of 85. He had been on the staffs of Alexian Brothers, Columbus-Cuneo and American Hospitals. Dr. Burket was also a clinical associate in surgery at the University of Chicago Medical School. He had practiced medicine for more than 50 years.

*Conley, Thomas J., Park Ridge, died February 24, at the age of 67. He was Past President of the Illinois Academy of Family Physicians; Past President of Resurrection Hospital medical staff and a former member of the St. Francis Hospital medical staff. He was a 1933 graduate of the University of Illinois.

*Gareiss, Alfred F., Palos Heights, died February 15, at the age of 72. He was a 1927 graduate of Northwestern University.

*Gollin, Harvey A., Lincolnwood, died Feruary 19, at the age of 77. He was Chairman of the Departments of Gynecology and Obstetrics at Columbus-Cuneo Hospitals, an assistant professor of obstetrics and gynecology at Northwestern University Medical School and an attending physician at Cook County Hospital. Dr. Gollin was also a Past President of the U.S. Section of the International College of Surgeons. He was a graduate of 1942 from the University of Wisconsin.

*Gross, Erick M., Chicago, died February 16, at the age of 73. Until his retirement two years ago he was on the staffs of the Michael Reese and Forkosh Hospitals. He was a 1925 graduate of the University of Bonn, Germany.

*Johner, Carl H., Evanston, died March 9, at the age of 40. He was a staff member at Evanston Hospital since 1968 and assistant professor in otolaryngology at Northwestern University Medical School.

*Jones, Morris H., Oak Park, died February 27, at the age of 74. He graduated from the Rush Medical School in 1926.

**Laibe, Joseph Eli, Chicago, died February 8, at the age of 77. He was a member of the American Board of Urology and the Chicago Urological Society. He was a 1922 graduate of the University of Illinois, and he had practiced medicine for more than 50 years .

*Lewison, Matthew, Michael, Chicago, died February 15, at the age of 66. He had been the Chief of Pediatrics at South Chicago Community Hospital in 1967 and received the State of Isreal's Achievement Award in 1963. Dr. Lewison was a 1932 graduate of Rush Medical School.

*Lockhart, Edmund S., Decatur, died February 23, at the age of 65. He was a graduate of the Washington University School of Medicine from 1936.

*Maller, Adolph M., Wilmette, died February 2, at the age of 60. He was a Past President of the American Hospital Association, a Vice President of the International College of Surgeons and Trustee of the International Surgeons Hall of Fame. He was a 1939 graduate of Loyola University Stritch School of Medicine.

*Mines, George, Chicago, died February 19, at the age of 50. He was a 1951 graduate of Frankfurt, Germany.

*Platt, Matthew, died March 6, at the age of 61. His death occurred during an Illinois State Medical Society tour to Quito, Ecuador. Dr. Platt was a former staff President and Chief of Medicine at Oak Park Hospital, and had been associated in teaching at Loyola University Stritch School of Medicine and County Hospital. He was a 1936 graduate of the University of Illinois.

*Rappaport, Ernest A., Chicago, died February 3, at the age of 70. He was a professor of psychiatry at Chicago Medical School and was a senior staff psychiatrist at Michael Reese Hospital.

*Wietrzykowski, John F., Chicago, died March 2, at the age of 73.

*Williams, Ernest B., Chicago, died January 30, at the age of 30. He was an attending internist and staff physician at the Porter Cancer Prevention Clinic of Chicago.

*Denotes member of ISMS
**Denotes member of 50-Year Club and ISMS

COOK COUNTY

Graduate School of Medicine

CONTINUING EDUCATION COURSES
STARTING DATES, 1974

SPECIALTY REVIEW IN DERMATOLOGY, May 6
SPECIALTY REVIEW IN OBSTETRICS & GYNECOLOGY, May 13
SPECIALTY REVIEW COURSE IN RADIATION SCIENCE, May 20
SPECIALTY REVIEW IN MEDICINE, CERTIFYING, June 10
SPECIALTY REVIEW COURSE IN FAMILY PRACTICE, August 12
SPECIALTY REVIEW COURSE IN ORTHOPAEDICS, August 25
SPECIALTY REVIEW COURSES IN PULMONARY & RHEUMATOLOGY, September 9
SPECIALTY REVIEW COURSES IN HEMATOLOGY, INFECTIOUS DISEASES AND NEPHOLOGY, September 30
SURGERY OF TRAUMA, 4 Days, May 13
ADVANCES IN SURGERY, One Week, May 6
ADVANCES IN NEONATOLOGY, Two Days, April 22
STATE & NATIONAL BOARD REVIEW, Basic and Clinical, April 29 & May 5
COMMON GENETIC DISEASES, One Week, May 6
MANAGEMENT OF TUMORS OF HEAD & NECK, One Week, June 10
NEUROMUSCULAR DISEASES OF CHILDREN, One Week, June 10
INTERMEDIATE ELECTROCARDIOGRAPHY, Two Days, May 9
ADVANCED PERIPHERAL VASCULAR SURGERY, One Week, July 15
NEUROLOGY, PART II, CLINICAL, One Week, September 9

Information concerning numerous other continuation courses available upon request.

Address:

REGISTRAR, 707 South Wood Street,
Chicago, Illinois 60612

CLASSIFIED ADVERTISING

Positions & Practice Opportunities

BOARD CERTIFIED OR ELIGIBLE PSYCHIATRIST: The Illinois Department of Corrections invites qualified physicians to apply for this unique and challenging position, as consulting psychiatrist to three major correctional facilities in Southern Illinois. Board Certified or Eligible Physician, commencing salary $30,732. Liberal benefits include life and health insurance, annual leave, sick leave, retirement and social security. Interested physicians should write to Mr. Cecil Patmon, Medical Services Administrator, Illinois Department of Corrections, 160 North LaSalle, Room 425 Chicago, Illinois 60601 or call collect area code (312) 793-3216 9 a.m. to 4 p.m. daily.

INTERNAL MEDICINE — IMMEDIATE OPENING — DALLAS, TEXAS Southwest Clinic Association—15 man group—an established Clinic for over thirty-five years—moving to a new medical complex in mid-1974 with 350 bed acute care, full service hospital with private entrance from Clinic. Please direct inquiries to R. W. Windham, Administrator—220 Medical Arts Bldg.—Dallas, Texas 75201. Telephone (214) 742-2141.

"UNIQUE OPPORTUNITY"—We are seeking qualified **OBSTETRICIAN/GYNECOLOGISTS** for position of Director of Services and one or two assistants, in a busy Chicago West side Health Center to develop a program of innovative health care techniques. Director should have experience in general OB/Gyn and Health care administration. Those interested should contact either Dr. H. C. Bonbrest, Mile Square Health Centr, 2045 W. Washington, Chicago, Ill. 60612, phone (312) 942-3700, or Dr. G. D. Wilbanks Rush Presbyterian St. Luke's Medical Center, 1753 W. Congress Parkway, Chicago 60612, phone (312) 942-63B2.

MEDICAL SERVICE STAFF PHYSICIAN—218 bed modern general hospital with active medical and surgical services. Salary dependent upon qualifications. Excellent fringe benefits. Will pay moving expenses. License any state required. Equal opportunity employer. Contact Hospital Director, Veterans Administration Hospital, Fort Wayne, Indiana 46B05, or call (219) 743-5431, extension 310.

ER STAFFING IS CENTENNIAL YEAR PRIORITY for central Illinois community hospital, city and area of 55,000. **Needs ER physicians.** Balanced community: major national industries, two private colleges, new medical school nearby. Concerned medical staff, strong community support. Call collect (217) 245-9541, Administrator, Passavant Memorial Hospital, Jacksonville, Illinois 62650. Excellent recommendations required; excellent compensation offered.

Immediate openings for **INTERNAL MEDICINE, OB-GYN, PEDIATRICS.** Board certified or eligible. Outstanding opportunity to join multi-specialty group in mid-west resort area near Chicago. Salaried with partnership to follow; fringe benefits and unusually good income potential. Group building directly connected to 143 bed community hospital. Contact Edward F. Wilt, Jr., M.D.; McHenry Medical Group, 1110 North Green Street, McHenry, Illinois 60050 or call (B15) 3B5-1050.

WANTED—GENERAL PRACTITIONER OR INTERNIST to join staff of 176 bed Deans Committee VA Hospital. Excellent area recreation facilities. Beginning salary depending on qualifications. 30 days annual leave, 15 days sick leave, time to attend meetings and many other benefits. License any state. Contact Chief of Staff, VA Hospital, Marion, Ill. 62959. Telephone (618) 993-2151.

BOARD CERTIFIED ANESTHESIOLOGIST to head Department of Anesthesia for 450 bed Medical Center. Six thousand surgical procedures and twelve hundred deliveries. Three Anesthesiologists plus five Nurse Anesthetists. Affiliated with the University of Illinois College of Medicine. Salary plus fee for service. Terms and conditions open. Contact: Mr. Henry J. Kutsch, President, Ravenswood Hospital Medical Center, 4550 N. Winchester at Wilson, Chicago, Illinois 60640. (312) B78-4300, extension 247.

FAMILY PRACTICE—Opportunity for physician having residency or practice experience with the largest prepaid group in the Midwest. Our small family practice section is planning expansion into a fourth suburban clinic. Interested physicians will participate in our development. Ideal metropolitan setting with all services and opportunities. Competitive salary and liberal benefits. Contact J. Gutenkauf, M.D., Group Health Plan, 2500 Como Ave., St. Paul, Minn. 5510B, (612) 645-5851.

INTERNIST—Minneapolis-St. Paul. Midwest's leading prepaid group, democratically managed, offers high standards, rapid advancement, no investment, Generous vacation and conference leave, fully paid insurance and retirement. Teaching and professional pursuits encouraged. Superior schools, low crime rate and clean environment. Ronald W. Ellis, M.D., 2500 Como Avenue, St. Paul, Minn. 5510B.

Positions & Practice Opportunities (Con't)

OBSTETRICIAN WANTED to associate with rapidly growing four-physician OB-GYN department in prepaid multi-specialty group. Generous compensation, vacation and conference leave, fully paid insurance and retirement. Teaching and professional pursuits encouraged. Choice upper midwest metropolitan area abounding in year-round cultural and recreational opportunities. Contact M. M. Aksoy, M.D., FACOG, (612) 645-5B51, 2500 Como Avenue, St. Paul, Minn. 5510B.

IMMEDIATE FAMILY PRACTICE OPENING—in two man clinic. Libertyville, Illinois, 35 miles northwest of Chicago. Initial salary and early partnership. Busy practice in small suburban town. Call collect—Dr. Lawrence C. Day (312) 362-1447.

WANTED: OB-GYN, SURGEON and INTERNIST for nine man group. Thirty miles southwest of Chicago, excellent hospital, housing and schools. $30,000 guarantee first year. Write to Box Number 782, c/o Illinois Medical Journal, 360 N. Michigan Ave., Chicago, Illinois 60601.

ATTENTION PHYSICIANS! CHICAGO MEDICAL CENTERS—Welfare area in need of physicians. Please contact: Mr. Robert Fields (312) 236-2555.

GENERAL INTERNISTS and **GENERALISTS:** For growing sub-sections of 45 man medical department, including allergists, psychiatrists, neurologists, all sub-specialties and expanding primary care section. Multispecialty group of 120. Large patient population and area referral. Functioning HMO. Generous salary and fringe benefits. Peaceful setting near Wisconsin vacationland and cities. Good schools, cultural advantages, Junior College. Educational and research programs. Liberal schedules, little practice pressure. New Clinic and hospital developing. Write or call J. L. Struthers, M.D., Marshfield Clinic, Marshfield, Wisconsin 54449.

PHYSICIAN FOR ACUTE ILLNESS DEPARTMENT and Emergency Room. Become a part of an expanding, dynamic multispecialty clinic in Midwest University community. Excellent salary benefits. Write or call Medical Director, Carle Clinic, Urbana, Illinois 61B01. Phone (217) 337-3239.

GENERALIST AND INTERNIST wanted to fill vacancies in Major Chicago Area Hospital. Associated with Medical Schools in Chicago. Salary Competitive. 40 hr. work wk. with excellent fringe benefits which include: vacation, paid sick time, holidays, pension plan, tuition reimbursement. Must be licensed in Illinois. Contact: Ms. L. Johnson, Employee Relations, Oak Forest Hospital, Oak Forest, Illinois 60452.

PHYSIATRIST—Major Chicago Area Hospital has openings available for Board certified or eligible physician to assume position in recently established Rehabilitation Center. 40 hour 5 day week with excellent fringe benefits. Contact Ms. L. Johnson, Employee Relations, Oak Forest Hospital, Oak Forest, Illinois 60452.

PHYSICIAN WANTED: SPANISH SPEAKING M.D., For New Chicago area medical center. Phone: (312) 967-1374. After 6 p.m.

FAMILY PRACTITIONERS, INTERNISTS and PEDIATRICIANS: Full time salaried appointment to Medical Staff at Cook County Hospital with opportunity to practice half time or more in a community clinic. Write or call David McL. Greeley, M.D., Health and Hospital Governing Commission, 1900 West Polk Street, Chicago 60612, phone 633-BB25.

FAMILY PRACTITIONERS—Expanding BB0 bed multiple facility medical center in Chicago is seeking family practitioners (individual or groups) to join the staff of its family practice oriented facility—230 bed hospital located on the near West Side. The hospital will provide an office and furnish equipment to establish private practice at a mutually agreeable site in the nearby community—no investment by physicians required—and guarantee annual private practice income to a $36,000 minimum for one to five years (negotiable). Send Curriculum Vitae to Box 825, c/o Illinois Medical Journal, 360 N. Michigan Avenue, Chicago, Illinois 60601.

OZAUKEE COUNTY NEEDS Family Practitioners, Orthopedist, and Pediatricians to provide health care for over 55,000 affluent people. St. Alphonsus Hospital, located in the center of Ozaukee County, is an orderly, modern facility ready to provide acute hospital care. Office space is available here and in nearby cities and villages. Contact George A. Seidenstricker at St. Alphonsus Hospital, 743 North Montgomery Street, Port Washington, Wisconsin 53074. Phone 414-2B4-5511.
P.S. Spend the day with us so we can show you and your family everything . . . schools, shops, homes, parks.

BLUE SHIELD REPORT FOR *Illinois Physicians*

New Procedure for Better Service

A significant number of Blue Shield claims are delayed in process, many of which are eventually disapproved, for reasons related to membership eligibility. A Physician's Service Report may be filled out completely with the membership information given, but through error in transcription or subsequent change in family or employment status, the data may be incorrect and result in adjudication delays.

For example, incorrect group/subscriber numbers are given; membership may have expired or lapsed; coverage in effect is for Blue Cross only; no dependents are covered, etc.

Blue Shield does its best with these claims to correct or complete membership identification numbers where possible with little delay in the processing of the claims, *and we will continue to do so.* Where this is not possible, however, we have been corresponding with our member regarding the problem, notifying him that he must provide us verification of the patient's current membership. To date Blue Shield has not been notifying the physician or other provider of benefits until the claim is finally disapproved which has sometimes been many weeks later.

A full administrative analysis indicates that a change in procedure is called for to improve service to all concerned. Physicians filing service reports on behalf of their patients should be informed of delays encountered as soon as possible. Therefore, a change in procedure will be put into effect on or about May 1st.

At the same time that a member is notified of a positive discrepancy between our records and the information given on the claim form, the Physician's Service Report will be returned to the doctor together with a copy of the member's questionnaire.

It is the obligation of the member to establish properly the patient's eligibility for Blue Shield benefits and he will be informed that the claim has been returned to the physician's office. If he is unable to verify Blue Shield coverage, he must assume full responsibility for the physician's charges.

We believe this prompt notification of membership delay will benefit the physician by eliminating written or telephone inquiries and resubmission of duplicate claims. We expect this new procedure will have long-lasting positive results for our physicians and members as well.

New Blue Shield Physician's Service Reports Distributed

Deliveries of the new Blue Shield Physician's Service Report forms to physicians' offices throughout the state began the first week of May and were expected to be completed by May 15.

Notices enclosed with a supply of the new forms requested that physicians begin using them immediately, and to destroy or discard the present forms you have on hand.

Before you begin using the new Service Reports, please check the physician identification code number imprinted on the form to assure it is accurate. Your identification code number remains the same as the one you were assigned.

If any corrections are necessary, contact the Physician's Code Section, Blue Shield Plan of Illinois Medical Service, 233 North Michigan Ave., Chicago, Illinois 60601.

When you need to reorder, please use the color-coded order form provided for the purpose and return it to the Blue Shield office, above address, attention of Physician's Code Section. You will expedite delivery by using the order form.

Changes in the Physician's Service Report form were made to improve service to you and our members with the adoption of a new claims processing system to produce faster and more accurate payments of Blue Shield benefits.

(This report is a service to the physicians of Illinois)

Complete Information Necessary On Medicare Claims

From the first of the year through March 1974, Illinois Medical Service, Part B Medicare carrier for Cook County, received nearly 325,000 claims for benefits. This is a higher monthly average than last year, when over a million claims were received and processed in a 12-month period.

A study of claims submitted shows that nearly 15 per cent are delayed in processing because necessary information on the SSA 1490, Request for Medicare Payment form is omitted, or an itemized statement containing the essential information was not submitted with the SSA 1490 form.

The three items most frequently missing from Medicare claims are: (1) The diagnosis (2) Itemization of all charges (3) Itemization of specific charges.

The diagnosis is essential for the Part B carrier to relate the services provided to the treatment of the illness or injury. It must be included on the physician's statement to the patient when billing the patient directly. This eliminates the need for contacting the physician for the diagnosis when the patient files for benefits and neglects to complete line 4 of the SSA 1490.

Itemization of all charges means listing the date of each service, place of service, description of each service, whether surgical or medical, nature of illness or injury, and charge for each service on the SSA 1490 or statement to the patient. For example, a bill for several office visits plus in-hospital medical care should list the date and charge for each office visit plus the dates and charge for the in-hospital care.

Itemization of specific charges means to list the charges for each specific service included in an overall charge. For example, a charge for an office visit during which a complete blood count and an X-ray were taken should include the specific fee for the complete blood count and for the X-ray plus the charge for the office visit.

Similarly, a charge for in-hospital visits should show the number of days the patient was visited and the charge for each day. If the fee for the initial visit exceeds that of subsequent visits, the difference in the amount charged must be shown.

Below is listed the specific information which is required on all claims for Medicare benefits. On Part I of the 1490:

(1) Give the complete name of patient as listed on patient's Health Insurance Card.

(2) Every claim submitted must include the patient's complete Health Insurance claim number, and the letter suffix, as it appears on the patient's Health Insurance Card. Adjacent to the letter suffix are boxes to indicate whether the patient is a male or female. Because names are confusing either box should be completed.

(3) Patient's address and telephone number. This helps to establish the correct identity of the patient.

(4) Diagnosis and description of illness or injury.

(5) Name of supplementary insurance company and address; policy number; or Public Aid number.

(6) Signature of the patient.

Beginning with Part II of the form or attached itemized statements:

(7) Date of service, place of service, full description of medical or surgical service, nature of illness or injury if not indicated in Part I, charge for each service.

(8) Name, address and telephone number of physician who provided the service. Please use the imprinted labels we furnish as these are specially coded to facilitate claim processing.

(9) Total charges.

(10) Amount paid.

(11) Any unpaid balance due.

(12) Please complete this item. If the box "I accept assignment" is not checked, payment will be made to the patient.

(13) Name and address of the facility where services were performed if other than home or office visits.

(14) Signature of physician. The signature certifies that the physician's services were personally rendered by him or under his personal direction; his professional degree and date of signature.

Please review all claims for completeness before you submit them. Claims completed correctly help us speed payments to you and your patients.

SSA Certifies New Laboratories

The following laboratories have been certified for participation in the Medicare program by the Social Security Administration:

Reymar Clinic Laboratory, Inc.
6032 South Halsted Street
Chicago, Illinois 60621
Provider Number 14-8269
Effective Date: August 31, 1973

Cermak Road Medical Laboratory
7120 West Cermak Road
Berwyn, Illinois 60402
Provider Number 14-8272
Effective Date: January 9, 1974

IMJ
Illinois Medical Journal

MAY, 1974 Vol. 145, No. 5 CONTENTS

Convention Summary

396 Abstracts of Board Actions
420 1974-75 Officers and Board of Trustees
421 Highlights of Convention
427 Summary of House of Delegates Action
431 Action on Resolutions

Clinical Articles

405 Xanthogranulomatous Pyelonephritis
N. Javadpour, M.D., and A. Farivari, M.D.
408 The Non-Visualizing Gallbladder
Jack L. Gibbs, M.D., and Carl R. Barthelemy, M.D.

Surgical Grand Rounds

410 Cecal Volvulus
John M. Beal, Editor

Cover Story

The cover of this month's *IMJ* depicts a highly visible beginning to the ISMS campaign for a state-level medical review program superior to the federal Professional Standards Review Organization.

On the cover is a representation of a poster distributed last month to every hospital in Illinois. The purpose: to tell physicians that ISMS has a better way than PSRO—a *voluntary* system for medical review.

The poster design also was incorporated into a brochure explaining the Illinois alternative to PSRO, and listing actions by the ISMS House of Delegates as it responded to the wishes of most Illinois physicians. The House has directed ISMS to develop an alternative to PSRO, and to initiate an educational program for physicians, lawmakers and the public.

A special $25.00 assessment to dues-paying members will provide start-up funds for the Illinois alternative to PSRO and finance any educational program utilizing increased mailings of ACTION REPORT to all ISMS members; newspaper advertising; dissemination of editorial material to the mass media, and placement of ISMS speakers on the air and before lay audiences.

Under the ISMS alternative, a consortium of physicians, osteopaths and other representatives of the health care sector will administer a statewide medial review program which will meet standards and requirements superior to those set by the government. Review activities will be performed at the local level by local physicians, following guidelines and criteria reflecting the area's needs, rather than directives from Washington.

(Contents continued overleaf)

Features

392 President's Page

402 Clinics For Crippled Children

412 New Pharmaceutical Specialties

413 EKG of the Month

414 View Box

415 Editorial

416 Pulse of the Doctor's Wife

418 Illinois Housestaff News

437 Doctor's News

440 Obituaries

441 Physician Recruitment

448 ISMS Guide to Continuing Medical Education

(Inside cover, page 419, by Alicia Kolton)

Staff

Editor **Theodore R. Van Dellen, M.D.**

Managing editor **Richard A. Ott**

Assistant editor **Joyce Gallagher**

Executive administrator **Roger N. White**

PUBLICATIONS COMMITTEE

Jacob E. Reisch, M.D., Springfield, *Chairman*
Eugene T. Hoban, M.D., Oak Park
Frederick E. Weiss, M.D., Harvey
James A. McDonald, M.D., Geneva
Warren W. Young, M.D., Crete

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Medical Progress: Harvey Kravitz, M.D., Skokie
Contributor in Maternal Death Studies:
Robert Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth A. Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood

ILLINOIS STATE MEDICAL SOCIETY

360 N. Michigan Ave., Chicago, 60601

OFFICERS

Fredric D. Lake, M.D., President
1041 Michigan Ave., Evanston 60202

J. M. Ingalls, M.D., President-Elect
502 Shaw, Paris 61944

Harold A. Sofield, M.D., 1st Vice-President
715 Lake Street, Oak Park 60301

Robert Hartman, M.D., 2nd Vice-President
1515A W. Walnut Street, Jacksonville 62650

Jacob E. Reisch, M.D., Secretary-Treasurer
1129 S. 2nd St., Springfield 62704

HOUSE OF DELEGATES

Andrew J. Brislen, M.D., Speaker of the House
6060 S. Drexel Blvd., Chicago 60637

James A. McDonald, M.D., Vice-Speaker
13 S. 2nd St., Geneva 60134

TRUSTEES

1st District: 1977, Joseph L. Bordenave, M.D.
1665 South Street, Geneva 60134

2nd District: 1977, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364

3rd District: 1976, David S. Fox, M.D.
20829 Greenwood Center Ct., Olympia Fields 60461

3rd District: 1976, Robert T. Fox, M.D.
2136 Robin Crest, Glenview 60025

3rd District: 1975, Eugene T. Hoban, M.D.
6429 North Ave., Oak Park 60302

3rd District: 1975, Joseph Skom, M.D.
707 Fairbanks Ct., Chicago 60611

3rd District: 1977, William M. Lees, M.D.
6518 North Nokomis, Lincolnwood 60646

3rd District: 1977, George Shropshear, M.D.
1525 E. 53rd St., Chicago 60615

3rd District: 1977, Philip G. Thomsen, M.D.
13826 Lincoln Ave., Dolton 60419

3rd District: 1976, Frederick E. Weiss, M.D.
15643 Lincoln, Harvey 60426

3rd District: 1975, Warren Young, M.D.
3450 Haweswood Dr., Crete 60417

4th District: 1976, Fred Z. White, M.D.
723 N. 2nd St., Chillicothe 61523

5th District: 1976, A. Edward Livingston, M.D.
326 Fairway Dr., Bloomington 61701

6th District: 1975, Mather Pfeiffenberger, M.D.
State and Wall Sts., Alton 62002

7th District: 1976, Arthur F. Goodyear, M.D.
142 E. Prairie, Decatur 62523

8th District: 1976, Eugene P. Johnson, M.D.
P.O. Box 68, Casey 62420

9th District: 1975, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946

10th District: 1975, Herbert Dexheimer, M.D.
301 S. Illinois, Belleville 62220

11th District: 1977, Ross Hutchison, M.D.
126 E. Ninth St., Gibson City 60936

Trustee-At-Large: Willard C. Scrivner, M.D.
6600 West Main, Belleville 62223

Chairman of the Board: Joseph L. Bordenave, M.D.
1665 South Street, Geneva 60134

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/ Clinical Practice.*

Published by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601 (312-782-1654)

Copyright, 1974. The Illinois State Medical Society.

Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail).

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

cannibal stomach



add Pro-Banthine

Helps to relieve pain without risk of patient drug dependency.

add Pro-Banthine

Reduces gastric secretory volume and total resting and free acid without the caloric, digestive, and social problems occasioned by frequent eating.

add Pro-Banthine

Pro-Banthine slows intestinal motility to enhance and prolong the action of antacids. The action of Pro-Banthine lasts 4 to 6 hours.

*Fordtran, J. S., and Collyns, J. A. H.: Antacid Pharmacology in Duodenal Ulcer: Effect of Antacids on Postcibal Gastric Acidity and Peptic Activity, New England J. Med. 274:921-927 (April 28) 1966.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to: G. D. Searle & Co. Medical Department, Box 5110, Chicago, Ill. 6068(

usually get better patient response.

occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

Pro-Banthine P.A.—Each tablet of Pro-Banthine P.A. (propantheline bromide) contains 30 mg. of the drug in the form of sustained-release or timed-release beads; on ingestion about half of the drug is released within an hour and the remainder continuously as earlier increments are metabolized. Thus the result is even, high-level anticholinergic activity maintained all day and all night in most patients with only two tablets daily. Some patients may require one tablet every eight hours.

The contraindications and precautions applicable to Pro-Banthine 15 mg. should be observed.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.



President's Page

Double Trouble

The following is adapted from Dr. Lake's inaugural address before the ISMS House of Delegates on April 6, 1974.

Organized medicine in Illinois is in trouble . . . double trouble!

We individually—you and I as practicing physicians—are in trouble . . . and we collectively—as the Illinois State Medical Society—are in trouble.

We are torn from within by discord, and we are the target of unending assaults from without—assaults upon our professional practice, our professional judgment, and our professional freedom—assaults launched by government and by socialistically inclined segments of the public.

If we are to deflect successfully the arrows of outrageous fortune which assail us now, and which promise to rain down upon us with increasing fury, we must repair the wounded body of ISMS and return to battle with renewed vigor.

Since my earliest involvement in the affairs of this society, I have been dismayed by the undue attention accorded to geography in the deliberations of the House of Delegates and of the Board of Trustees. While I concede that environment—professional and personal—must be considered in weighing some of the problems facing us, I do not believe that such consideration should dominate the proceedings or the judgment of this society and its various organs. My colleagues on the Board of Trustees can attest to my constant concern in this regard, and to my efforts to mitigate preoccupation with this aspect of our lives.

Internal Relations Deteriorate

Since the Illinois State Medical Society recently discovered its fecundity and spawned a spate of organizations—Illinois Council on Continuing Medical Education, Illinois Foundation for Medical Care and Illinois Professional Standards Review Organization—geography has lost its ascendant role as the spoiler. While ICCME has been well-mannered, the local foundations and IFMC have caused considerable anguish. IPSRO still is a neonate and judgment of its behavior would be premature, but portents do appear that it, too, may join the foundations in causing us sleepless nights unless some prophylaxis is applied.

For more than two years—since the formation of the Illinois Foundation for Medical Care—I have watched our internal relations deteriorate. I am not indicting IFMC or the local foundations, nor am I criticizing their purpose. However, I believe that we must acknowledge their imperfections.

I am concerned about interlocking leadership and overlapping authority. I am equally concerned about unilateral efforts by foundations to secure PSRO designations. Although the lure for such action appears to be autonomy and money, the result will be fragmentation of organized medicine, subservience to the federal bureaucracy and—ultimately—the loss of our freedom. That is an exorbitant price to pay!

County Society Autonomy

Let me emphasize that foundations are not the sole cause of our present divisiveness. Relationships between the state society and some component societies—notably the Chicago Medical Society—have been strained for some time. This estrangement has been escalating since the advent of the foundations.

The Chicago Medical Society is the state's largest county unit, and provides the majority of ISMS members. If CMS were a state society, it would rank tenth in AMA membership. And last year, 12% of the new AMA members came from CMS. The Chicago Medical Society must be recognized as a major force in ISMS.

The relationship between ISMS and CMS often appears to put the cart before the horse. Certainly, any matters with statewide impact fall within the purview of ISMS. But anything which solely affects Chicago, or Rock Island, or Springfield, or any other component, is the responsibility of that society. ISMS should be available, of course, to render any assistance or expertise that may be requested.

I believe that CMS and some other component societies resent what they interpret as a paternalistic attitude on the part of ISMS. They are adult . . . some have considerable resources . . . and some aspire to do their own thing. I also believe that some would like to see what they perceive as domination by ISMS replaced by a more passive role.

Failure to clearly define the respective roles and relationships of the state medical society, the component societies and their offspring has contributed to the ferment. These tensions are seriously eroding the effectiveness of each organization. The internecine conflicts on both professional and staff levels must be eradicated! And the roles, privileges and duties of each organization must be clearly delineated.

The state society has an obligation to respect the sovereignty and maturity of its components and to studiously avoid interference in local matters. On the other hand, component societies have an obligation to recognize the authority of the House of Delegates and to abide by promulgated policies.

I believe it is imperative that we ask some probing questions about the governance and structure of organized medicine in Illinois:

- Should the county medical society necessarily remain the basic unit?
- Is a minimum size necessary to maintain a viable, meaningful society?
- Should regional societies be created to coalesce the membership of sparsely populated counties into an effective organization?
- Should we create stronger district organizations and decentralize some activities of ISMS headquarters?
- Do ISMS and county societies share their experiences, facilities and expertise in areas such as health care delivery, governmental affairs, membership recruitment and public relations?
- Do we need as many councils and committees as we have . . . or do we need more? Are they relevant and productive . . . or have some outlived their purpose and usefulness? Would a careful evaluation of their functions indicate that some should be eliminated . . . their purpose changed . . . or their membership strengthened by the infusion of new blood?

Make the Machinery Work

I suggest that the vitally important councils—such as those dealing with governmental affairs—should be structured vertically to insure that activities are coordinated with component societies . . . new ideas are not lost . . . and everyone is on the same track.

We've all heard occasional muttering among the membership that a handful of physicians seems to dominate the majority of our activities and wear all the hats. This is true, in part, because these men are the workhorses—the doctors upon whom we can always count to give unstintingly of their time and their talents. I say that it is time to give them some help.

Let's find ways to interest more doctors—and younger doctors—in making the machinery of organized medicine work.

Throughout the state there is a vast reservoir to be tapped—a reservoir of doctors who must become involved. We must seek them out; we must actively recruit them and engage them in work on councils and committees at all levels.

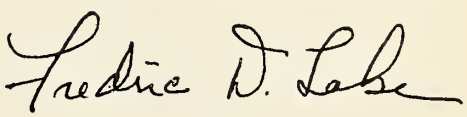
Investigation Urged

In this enumeration of our troubles, let it be understood that I am not pointing the finger of blame in one direction or the other. I suspect that some fault lies on all sides. To get to the root of our problems and formulate workable solutions, I suggested in my inaugural address that the Speaker of the House of Delegates appoint a select committee to investigate the situation and report its findings and recommended solutions to the House during its meeting next year. I also suggested that, in view of the magnitude of the assignment, it would be desirable to appoint subcommittees to concentrate upon specific areas.

Let me turn now to the question I have been asked innumerable times this past year: "What is your platform?"

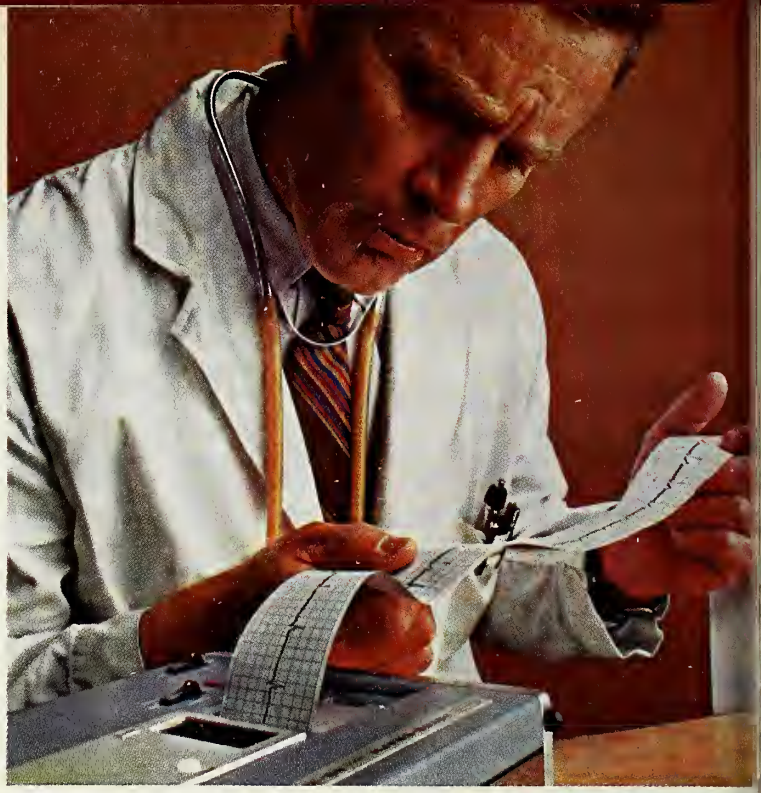
I answered this question in my inaugural address, when I pledged to the House of Delegates that during my year as President of the Illinois State Medical Society:

- I shall first and foremost endeavor to heal the wounds.
- I shall endeavor to heighten the interest of academia and of the specialty societies in organized medicine.
- I shall endeavor to awaken the dormant interest of our large membership in the affairs of this society, and to bring our members to a realization that only through concerted actions and harmony can we successfully ward off the many threats to our freedom.
- I shall endeavor to support to the best of my ability the goals and purposes of this great society.



Editor's Note: The House of Delegates voted to accept Dr. Lake's suggested appointment of a select committee to investigate problems within organized medicine in Illinois. The names of the committee members were not available at press time.

When cardiac complaints occur in the absence of organic findings, underlying anxiety may be one factor



The influence of anxiety on heart functio

Excessive anxiety is one of a combina tion of factors that may trigger a series o maladaptive functional reactions which car generate further anxiety. Often involved ir this vicious circle are some cardiac arrhyth mias, paroxysmal supraventricular tachycar dia and premature systoles. When these symptoms resemble those associated with actual organic disease, the overanxiou patient needs reassurance that they have nc

Before prescribing, please consult complete product information a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accom panying various disease states.

Contraindications: Patients with known hypersensitivity to the drug

Warnings: Caution patients about possible combined effects with alco hol and other CNS depressants. As with all CNS-acting drugs, caution patient against hazardous occupations requiring complete mental alertness (*e.g.*, oper ating machinery, driving). Though physical and psychological dependenc have rarely been reported on recommended doses, use caution in administ ing to addiction-prone individuals or those who might increase dosage; with drawal symptoms (including convulsions), following discontinuation of th drug and similar to those seen with barbiturates, have been reported. Use o any drug in pregnancy, lactation, or in women of childbearing age require that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six limit to smallest effective dosage (initially 10 mg or less per day) to preclud ataxia or oversedation, increasing gradually as needed and tolerated. Not rec ommended in children under six. Though generally not recommended, i combination therapy with other psychotropics seems indicated, carefull consider individual pharmacologic effects, particularly in use of potentiatin drugs such as MAO inhibitors and phenothiazines. Observe usual precaution

rganic basis and that reduction of exces-
ve anxiety and emotional overreaction
ould be medically beneficial.

he benefits of antianxiety therapy

Antianxiety medication, when used to
mplement counseling and reassurance, should
both effective and comparatively free from
ndesirable side effects. More than 13 years of
tensive clinical experience has demonstrated
at Librium (chlordiazepoxide HCl) fulfills
ese requirements with a high degree of con-
tency. Because of its wide margin of safety,
brium may generally be administered for ex-
nded periods, at the physician's discretion,
thout diminution of effect or need for increase
dosage. If cardiovascular drugs are necessary,
brium is used concomitantly whenever anxiety
a clinically significant factor. Librium should
discontinued when anxiety has been reduced
appropriate levels.

For relief of
excessive anxiety
adjunctive
Librium® 10 mg
(chlordiazepoxide HCl)
1 or 2 capsules t.i.d./q.i.d.
ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

presence of impaired renal or hepatic function. Paradoxical reactions
., excitement, stimulation and acute rage) have been reported in psychi-
c patients and hyperactive aggressive children. Employ usual precautions
reatment of anxiety states with evidence of impending depression; suicidal
dencies may be present and protective measures necessary. Variable effects
blood coagulation have been reported very rarely in patients receiving the
g and oral anticoagulants; causal relationship has not been established
ically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, espe-
ly in the elderly and debilitated. These are reversible in most instances by
per dosage adjustment, but are also occasionally observed at the lower
age ranges. In a few instances syncope has been reported. Also encountered
isolated instances of skin eruptions, edema, minor menstrual irregularities,
sea and constipation, extrapyramidal symptoms, increased and decreased
ido—all infrequent and generally controlled with dosage reduction; changes
EG patterns (low-voltage fast activity) may appear during and after treat-
t; blood dyscrasias (including agranulocytosis), jaundice and hepatic dys-
tion have been reported occasionally, making periodic blood counts and
r function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlor-
epoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg
rdiazepoxide.

Abstracts of Board Actions

April 2-6, 1974 **Conrad Hilton Hotel, Chicago**

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

Illinois Alternative to PSRO

The Board approved for presentation to the House of Delegates a supplementary report of the chairman requesting the House of Delegates to pass a $25 mandatory assessment on each ISMS dues-paying member to finance an educational campaign and provide start-up funds for the Illinois alternative to PSRO. The assessment would replace a voluntary $10 contribution voted by a special session of the House on February 24.

The educational campaign—aimed at members, legislators, patients and the general public—would stress the deleterious effect of PSRO and other objectionable regulatory control portions of P.L. 92-603, as well as the positive aspects of a new statewide medical review program to be operated by a consortium of representatives of hospital associations, nursing homes, the Illinois Department of Public Aid, Comprehensive Health Planning, Health Insurance Council, Blue Cross-Blue Shield, and doctors of medicine and osteopathy.

Using the Hospital Admission and Surveillance Program as a prototype, the Illinois Professional Standards Review Organization will devise overall guidelines and make necessary administrative arrangements to create a unified program of institutional review throughout Illinois, with these reviews done by local medical review organizations formed by physicians in geographic areas.

Medical Disciplinary Board

Proposed legislation to create a state medical disciplinary board was approved by the Board following endorsement of the concept by the House of Delegates.

Medical Examining Board

Retention of Drs. Kenneth Schnepp and Warren Tuttle on the Medical Examining Committee will be urged by the Board of Trustees, which will also nominate Frank J. Jikra, Jr., M.D., if additional appointments are to be made to this Committee.

Medical Review Board for Secretary of State

ISMS has recommended that the Secretary of State appoint a seven-member review board to advise his office on the issuance of driver's licenses. Nominations are Harold Sofield, M.D., Oak Park, orthopedic surgeon; Wesley Betsill, M.D., Springfield neurologist; Frank Norbury, M.D., Jacksonville, internist; Paul Schmidt, M.D., Galva, family physician, and Ronald Shlensky, M.D., Chicago, psychiatrist.

Immunization

The Board endorsed efforts to close a legislative loophole which allows parents to challenge immunization requirements on the grounds that they are not mandated in the Illinois School Code.

Appointments Ratified

William M. Lees, M.D., to represent ISMS on the Illinois Cancer Council Board of Trustees; Al Ray, M.D., Joliet, to represent ISMS at the National Drug Abuse Conference, March 30 through April 1 in Chicago; and Max Klinghoffer, M.D., Elmhurst, and Ralston Hannas, M.D., Lake Forest, as representative and alternate representative to a newly-developed Advisory Committee for Emergency Services. The advisory committee—sponsored by seven Illinois based organizations—will offer its services to the Illinois Department of Public Health and any other organization or community working in the area of emergency services.

Speakers Training Seminar

All ISMS officers, trustees, council and committee members, delegates and alternates will be invited to participate in an AMA Speakers Training Seminar, May 25 and 26, at the Marriott Hotel, Chicago. Registration will be limited, and ISMS will reimburse participants for travel, food and hotel expenses.

Medical Audit Seminar

ISMS will co-sponsor a Medical Audit Team Seminar, June 18 and 19, at the Southern Illinois University campus in Carbondale.

Medical Staff Liability Coverage

The Board endorsed the following statement developed by the Executive Committees of ISMS and the Illinois Hospital Association:

> "It is the responsibility of the hospital governing board to assure itself that a physician's license to practice medicine and his professional liability insurance are current and in force. This assurance should be provided by the medical staff.
>
> To accomplish this, medical staffs are encouraged to make provision in their bylaws to require physicians seeking appointments and continued reappointment to show evidence of adequate professionnal liability coverage as well as their license to practice medicine.
>
> These factors should be a part of the credentialing criteria for determining the physician's qualifications for appointment and reappointment."

Dr. Jirka is Candidate for AMA Board of Trustees

Frank J. Jirka, Jr., M.D., ISMS Past President, is a candidate for the Board of Trustees of the American Medical Association. Official support and endorsement was announced by the ISMS Board of Trustees and the Illinois Delegation to the AMA. All members of the society are urged to write friends in other state delegations in support of Dr. Jirka's election in June.

ASPIRA Request for Funding

The Board awarded a $10,000 grant to ASPIRA of Illinois, Inc., to maintain its health careers program for Spanish-speaking students. The money will be allocated from the Unmet Medical Needs fund of the ISMS Educational & Scientific Foundation.

Human Chorionic Gonadotropin in Treatment of Obesity

A position paper on "The Use of Human Chorionic Gonadotropin (HCG) in the treatment of obesity," was approved by the Board. The position paper states that: "Until such time as (scientific) studies are undertaken (on the use of HCG in treating obesity) the public should be cautioned against indiscriminate use of a therapy as yet not shown to have short term or lasting benefit."

Home Rule Unit Licensure and Regulation by and of Physicians

Legal counsel has been instructed to analyze an Illinois Supreme Court decision upholding the right of Chicago and other home rule units to license and regulate 30 professions and trades and to prepare legislation immediately to prevent the licensure and regulation of physicians by home rule units.

Emergency Medical Service Act

ISMS will support proposed amendments to the Emergency Medical Treatment Act (Public Act 77-2295) deleting the word "pilot" from the law to enable paramedic programs to continue in operation; mandate the Ill. Department of Public Health to consult with an advisory committee of MDs, RNs and paramedical personnel who are actually engaged in providing services under this act before issuing guidelines for the program; and allowing an RN authorized by an MD and the hospital to monitor electro-cardiograms in the temporary absence of a physician.

Mental Health Community Review Act

Recommendations of the Council on Mental Health and Addiction relating to HB 2223, the Mental Health Community Review Act, were referred to the Govern-

(Continued on page 451)

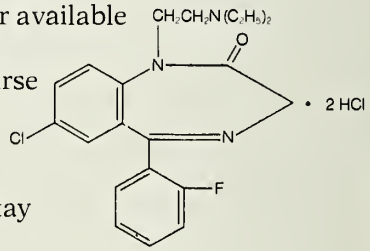


Dalmane®
(flurazepam HCl)

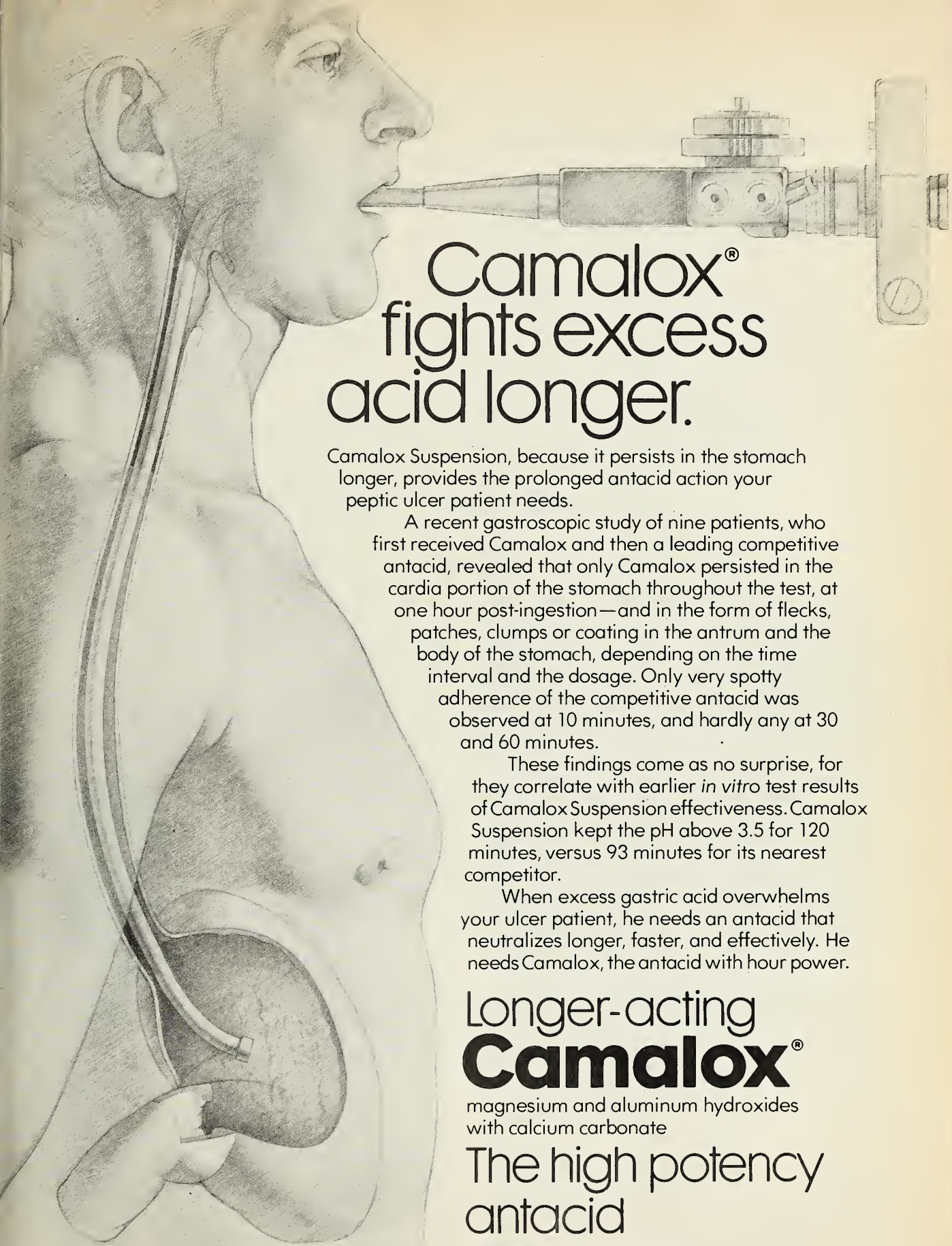
Distinctiveness that begins with the benzodiazepine structure

Distinctive sleep potential in the flurazepam HCl molecule

Dalmane (flurazepam HCl) is a distinctive sleep medication—a benzodiazepine specifically indicated for insomnia. It is not a barbiturate or methaqualone, nor is it related chemically to any other available hypnotic.



In the most rigorous course of clinical evaluation ever accorded a sleep medication in the sleep research laboratory, Dalmane has repeatedly been shown effective in helping patients fall asleep promptly, stay asleep and sleep longer.[1-7]



Camalox® fights excess acid longer.

Camalox Suspension, because it persists in the stomach longer, provides the prolonged antacid action your peptic ulcer patient needs.

A recent gastroscopic study of nine patients, who first received Camalox and then a leading competitive antacid, revealed that only Camalox persisted in the cardia portion of the stomach throughout the test, at one hour post-ingestion—and in the form of flecks, patches, clumps or coating in the antrum and the body of the stomach, depending on the time interval and the dosage. Only very spotty adherence of the competitive antacid was observed at 10 minutes, and hardly any at 30 and 60 minutes.

These findings come as no surprise, for they correlate with earlier *in vitro* test results of Camalox Suspension effectiveness. Camalox Suspension kept the pH above 3.5 for 120 minutes, versus 93 minutes for its nearest competitor.

When excess gastric acid overwhelms your ulcer patient, he needs an antacid that neutralizes longer, faster, and effectively. He needs Camalox, the antacid with hour power.

Longer-acting **Camalox®**

magnesium and aluminum hydroxides with calcium carbonate

The high potency antacid

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

Clinics for Crippled Children Listed for June

Twenty-six clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 20 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social and nursing services. There will be five special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

June 4 Belleville—St. Elizabeth's Hospital
June 4 Carmi—Carmi Township Hospital
June 5 Hinsdale—Hinsdale Sanitarium
June 6 Sterling—Sterling Community Hospital
June 6 Flora—Clay County Hospital
June 6 Springfield—St. John's Hospital
June 6 Lake County Cardiac—Victory Memorial Hospital
June 10 Peoria Cardiac—St. Francis Children's Hospital
June 11 Peoria—St. Francis Children's Hospital
June 11 East St. Louis—Christian Welfare Hospital
June 12 Champaign-Urbana—McKinley Hospital
June 12 Springfield Pediatric-Neurology—Diocesan Center
June 13 Rockford—St. Anthony Hospital
June 13 Kankakee—St. Mary's Hospital
June 14 Chicago Heights Cardiac—East Chicago Heights Community Center, Inc.
June 18 Alton—Alton Memorial Hospital
June 18 Rock Island—Moline Public Hospital
June 19 Chicago Heights—East Chicago Heights Community Center, Inc.
June 20 Bloomington—Mennonite Hospital
June 20 Elmhurst—Memorial Hospital of DuPage County
June 24 Peoria Cardiac—St. Francis Children's Hospital
June 25 Peoria—St. Francis Children's Hospital
June 25 Danville—Lake View Hospital
June 26 Aurora—St. Joseph Mercy Hospital
June 28 Evanston—St. Francis Hospital
June 28 Chicago Heights Cardiac—East Chicago Heights Community Center, Inc. ◄

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.

WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

PR-GP-31-B/W

IMJ
Illinois Medical Journal
Vol. 145, No. 5, May 1974

Xanthogranulomatous Pyelonephritis

By N. Javadpour, M.D., and A. Farivari, M.D./Washington, D.C.

XANTHOGRANULOMATOUS pyelonephritis (XGP) is a relatively rare manifestation of a chronic inflammatory disease of the kidney frequently simulating renal cell carcinoma and renal tuberculosis. Javadpour and Mostofi reported 56 cases of XGP from the file of the Armed Forces Institute of Pathology to the American Urological Association in Philadelphia in May, 1970.[1] Clinically, 11 of the 56 cases were initially diagnosed renal cell carcinoma. Histologically, 14 were reported as renal cell carcinoma by the original contributors. Because of the similarities between XGP and renal cell carcinoma, it is difficult to make the accurate preoperative diagnosis that is essential for proper surgical approach, postoperative therapy, and prognosis.

We have encountered eight such cases at Cook County Hospital in the past four years. Five of the eight have been diagnosed preoperatively. We would like to present a representative case in detail and discuss the clinical and pathologic diagnosis in an effort to prevent future erroneous therapy for this clinical entity.

N. JAVADPOUR, M.D., is Head of Urology and Senior Investigator at the National Institute of Health, Bethesda, Md. At the time of writing the article, he was from the Department of Urology at Cook County Hospital, The Chicago Medical School and the Hektoen Institute for Medical Research. He also is consultant to the National Naval Hospital and Walter Reed Army Hospital, Washington, D.C.

A. FARIVARI, M.D., is a research fellow in urology at the Armed Forces Institute of Pathology, Washington, D.C.



Figure 1. Excretory urogram revealing poor visualization of the left kidney; the right kidney visualized well.

Case Report

A 47-year-old Black woman entered the hospital on January 15, 1972, with a three-day history of left flank pain, fever, and dysuria. She had a history of essential hypertension and diabetes, but no prior history of urinary tract infection or stones.



Figure 2. A left retrograde pyelogram demonstrating what appears to be extravasation.

On admission a palpable, tender left upper quadrant mass was found. Urine culture revealed over 100,000 *E. coli* organisms per milliliter. An excretory urogram disclosed a large, poorly functioning left kidney with a normal right kidney (Fig. 1). A left retrograde pyeologram revealed nonobstructed upper and lower calyceal patterns with what appeared to be extravasation at the level of the middle major calyx (Fig. 2). A tentative diagnosis of XGP was made. A selective left renal vein (Fig. 3) phlebogram and a selective left renal arteriogram (Fig. 4) were compatible with an inflammatory mass.

On January 26, 1972, the left kidney was explored through a flank incision. It was found to be twice the normal size (305 grams), symmetrically enlarged, and containing multiple abscesses without perinephrinic extension. A left nephrectomy was performed. On cut section there was replacement of the renal parenchyma by soft yellow umbilicated nodules and dense white fibrous tissue, especially in the mid- and upper portions of the specimen (Fig. 5). Histologic examination revealed acute and chronic pyelonephritis. Aggregations of histiocytes loaded with lipoid material (foam cells) were found in the nodule. Oil Red O staining was positive—a characteristic of XGP. The postoperative period was uneventful. Follow-up excretory urogram revealed a normally functioning right kidney.

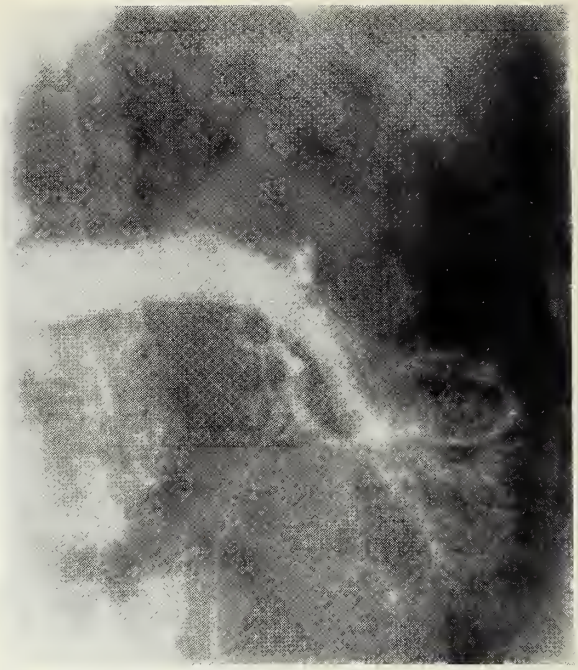


Figure 3. A selective left renal venogram shows occlusion of the superior branch of the renal vein. Note the ureteral catheter in the left renal pelvis.

Discussion

Authors have termed the process "staphylococcus of the kidney," "foam cell granuloma," "pyelonephritis xanthomatosis," "renal xanthomatosis," or "chronic pyelonephritis with xanthogranulomatous changes." The term xanthogranulomatous pyelonephritis is preferred, because it is descriptive of the histopathology of the lesion and is based upon the identification of histiocytes containing lipoid material, absence of malignant cells, and evidence of an inflammatory process.[1-10]

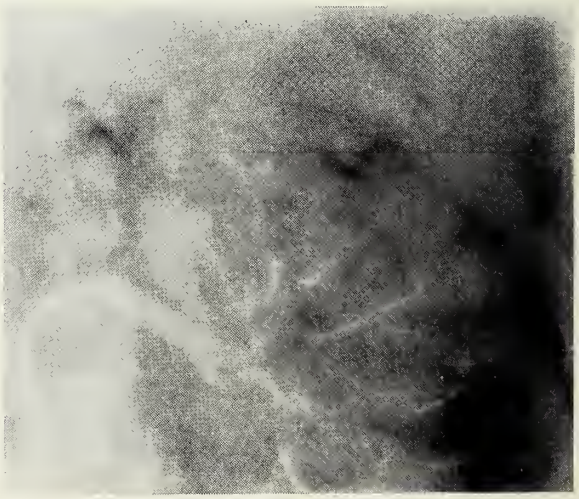


Figure 4. A left selective renal arteriogram. Note that the vessels are scattered. No extravasation or tumor vessels are seen.



Figure 5. Cut section of the left kidney. There is evidence of necrosis and abscess formation in upper pole. Note the soft umbilicated nodules in the middle portion.

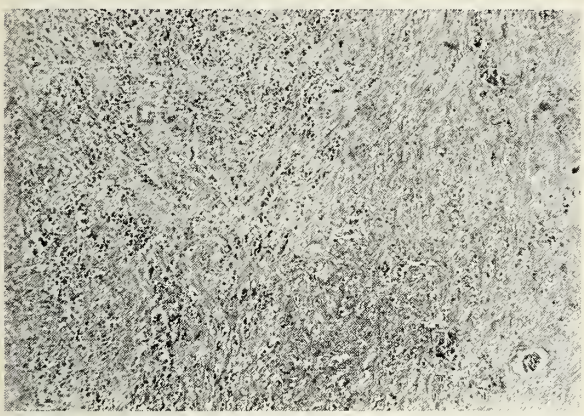


Figure 6. Diffuse pyelonephritis with scattered xanthomatous cells (foam cells).

Because clinical symptoms of XGP include flank or abdominal pain, fever, chills, pyuria, and calculous formation, it is frequently confused with renal cell carcinoma and tuberculosis. The disease may occur at any age, but is most common in the fourth to sixth decades; it is more frequently seen in males and relatively rare in the Black population. Pyuria is common, as is infection; *Proteus* organism is the most common bacteria identified.

The excretory urogram usually demonstrates an enlarged, nonfunctioning or poorly functioning kidney. The retrograde pyelogram often suggests this entity because of the presence of pseudo-extravasation of contrast material into the necrotic areas and around the xanthogranulomatous nodules.

Renal angiography is valuable in distinguishing XGP from renal cell carcinoma. In XGP the vascularity is scattered and there is no tumor staining. The inferior venocavogram and selective renal venogram delineate renal vein invasion. On gross examination, the involved kidneys are enlarged and pale, and the capsule is stripped with difficulty. On cut sections, the renal parenchyma is usually replaced by soft yellow nodules and dense, firm, white fibrous tissue. These nodules or fibrous tissue often extend into the peri-renal areas, and thus simulate carcinoma of the kidney.

On microscopic examination, the specimens show areas of inflammatory granulomatous infiltrate composed of histiocytes, lymphocytes, and plasma cells (Figs. 6, 7). The most important finding is large histiocytes with small pyknotic nuclei and foamy cytoplasm ("foam cells").

The lipoid globules are usually seen as a brilliant red when the sections are stained with Oil

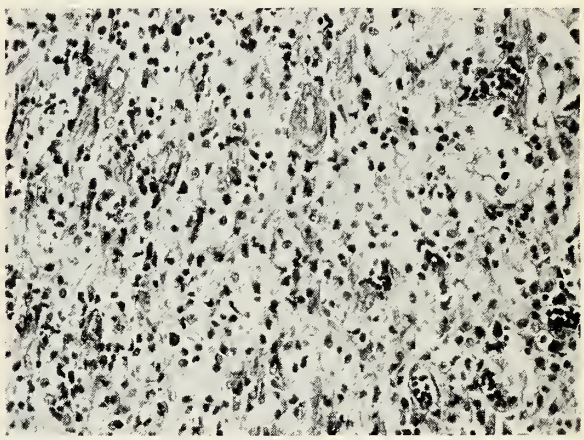


Figure 7. Higher magnification demonstrates a solid sheet of lipophages simulating clear cell carcinoma.

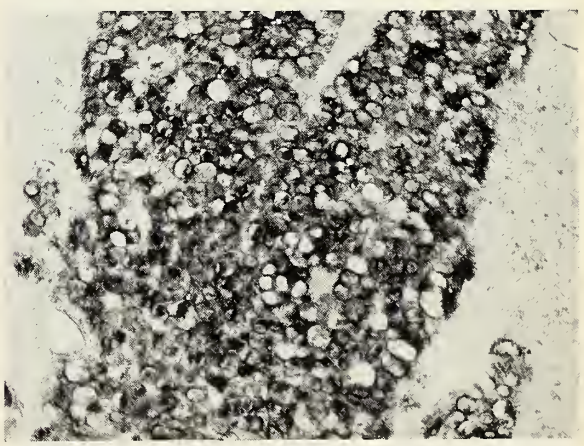


Figure 8. Oil Red O stain usually gives a bright red stain of the fat content of the macrophage.

(Continued on page 444)

The Non-Visualizing Gallbladder

By Jack L. Gibbs, M.D. and Carl R. Barthelemy, M.D./Canton

It is an unpleasant experience for the surgeon, a shock to the family, and a grim outlook for the patient when laparotomy for routine cholecystectomy reveals an incurable biliary tract carcinoma. After several such experiences in a relatively short period of time, we began to look for distinctive features which might help identify these patients preoperatively or alert us to the possibility of carcinoma prior to laparotomy.

We reviewed all cases of cancer of the biliary tract operated in our hospital during the years 1967 through 1970. There were 369 cholecystectomies performed, of which seven were for gallbladder or biliary duct carcinoma. This incidence, 1.9%, is somewhat higher than the 1% reported throughout the literature. Four of the patients were men and three were women and the ages ranged from 47 to 85 years. With the exception of two patients who were jaundiced when first seen, the symptoms were those routinely encountered with benign cholecystitis. Two patients had significant weight loss of 30 to 40 pounds. Liver function studies were obtained in four patients and were abnormal in the patients with clinical or sub-clinical jaundice. The onset of symptoms preceded surgery or hospitalization by as much as five years, the average time being 33 months. All patients with biliary carcinoma had complete lack of opacification of the gallbladder on either oral cholecystography or intravenous cholangiography. Six of these patients were operated upon. In three, the gallbladder was removed and in three with widespread involvement only a biopsy was done. In one patient, a nonfunctioning gallbladder was removed which proved to be essentially normal histologically. Five months later this patient became jaundiced and a subsequent operation revealed an extrahepatic biliary duct carcinoma. One patient with jaundice remained too critical for operation but the diagnosis was confirmed at autopsy. Only one patient has survived. He has no evidence of residual carcinoma 14 months following surgery. In this patient with a nonfunctioning gallbladder and no stones, the carcinoma was still in situ.



JACK L. GIBBS, M.D., Canton, is Chairman af the Department af Surgery at Graham Hospital, Canton and is a Clinical Assaciate Prafessor, Department af Surgery, at the Peoria Schaal af Medicine.

Dr. Gibbs is an active member af the Illinais State Medical Saciety and serves as a member af the Hause af Delegates af ISMS and the American Medical Association.



CARL R. BARTHELEMY, M.D., Canton, maintains a private practice in general surgery. Dr. Barthelemy serves an the ISMS Advisary Cammittee ta Physicians-in-Training.

Gallbladder carcinoma is rarely cured. It is the fifth most common carcinoma of the intestinal tract and accounts for approximately 6500 deaths yearly.[1] In a review of 1,061 cases, Strauch[2] reported only 11 five-year cures, and others have been unable to report a single long-term survivor. The usual five-year survival rate is 1 to 5%. Long-term cures of carcinoma of the gallbladder involve mainly those cases which, when operated upon for benign disease, have a small focus of unsuspected neoplasia. Our lone survivor is a case in point. Ackerman reports that the diagnosis of early carcinoma of the gallbladder is practically impossible. In 105 cases reported by Warren, only seven cases were diagnosed preoperatively.[3] Bockus states in his textbook, Gastroenterology, that there is a well established relationship between gallstones and carcinoma of the gallbladder.[4] The incidence of concomitance ranges from 60% to 90% in most reports. Ackerman and Regato[3] flatly state that cholecystitis and cholelithiasis are invariably accompaniments of carcinoma of the gallbladder. Others report that 90% of non-visualizing gallbladders contain stones and that 5% to 10% of people over 65 with symptomatic gallstones have carcinoma. This is an incidence 15 to 40 times that of the reported incidence (0.25% to 0.33%) in the general population.

Armed with such statistics, it seems to us that a good case can be made for early operation in all patients with gallstones and with non-visualiz-

ing gallbladders. In our patients, as in those reported by others, jaundice, weight loss, clinical symptoms, and laboratory findings were variable. The constant common finding was non-visualization of the gallbladder. Although cholecystography is primarily a test of the functional integrity of the gallbladder, non-function may result from primary disease in the extrahepatic biliary duct or pancreas. In one reported series, 10% of patients with non-visualization had normal gallbladders but had biliary duct or pancreatic disease.[5] This was true of our one case of biliary duct carcinoma. Usually, however, non-visualization of the gallbladder does mean gallbladder disease. In a recent issue of *Radiology Clinics of North America,* it was reported that 90% of gallbladders reported as having normal function were normal histologically, that stones, when reported, were present in 96%, and that 97% of gallbladders reported as nonfunctioning were diseased.[6] This prompted the following statement: "It seems paradoxical that an examination specifically designed to visualize the gallbladder should give one of its most accurate results when no visualization is obtained."[6]

Kirklin,[7] reporting in the *American Journal of Roentgenology* in 1932, said of cholecystography and gallbladder carcinoma, "A cholecystogram is useless as a diagnostic measure, for if carcinoma exists the gallbladder is not filled with dye." Viewed in another way, it may mean that cholecystography revealing nonfunction is a most important diagnostic measure. We feel this point is of paramount importance in prompt identification and treatment of biliary tract disease and thus in the potential reduction in deaths from biliary carcinoma.

It is apparent that nearly all patients with carcinoma of the gallbladder have clinical symptoms indistinguishable from those of benign cholecystitis and that the majority have had these symptoms for long periods of time. The average time between onset of symptoms and diagnosis and surgery in our patients was 33 months, and it is unlikely that the initial symptoms were due to carcinoma. In these cases it is possible that three additional patients might yet be alive if surgery had been performed when the diagnosis of biliary dysfunction was first made. Appleman,[8] of the Mayo Clinic, concludes in a review of long-term survivors of carcinoma of the gallbladder that some pass through a stage at which they are curable by extirpation. The fact that, except in rare cases, cure only follows limited operations for very early localized lesions and the lack of evidence of substantial improvement in the poor prognosis after radical surgery indicates that the stage of growth of the lesion and undefined biologic factors are the major determinants of prognosis.[8]

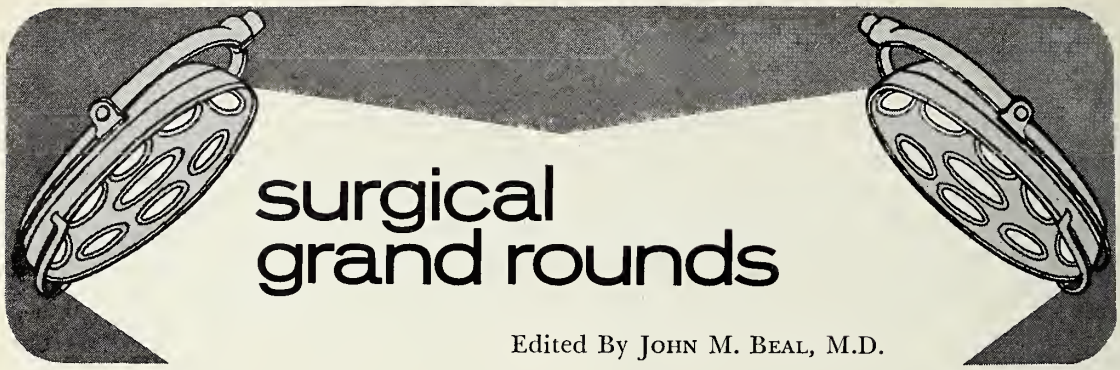
Strauch[2] concluded that carcinoma of the gallbladder continues to be remarkably resistant to all therapy. In the absence of effective surgical treatment for all but the earliest lesion, the best hope at present for reducing mortality from this disease lies in earlier cholecystectomy in patients with known benign gallbladder disease.

In a one-year review at our institution, 26 patients left the hospital unoperated with a diagnosis of chronic cholecystitis or cholelithiasis. Twenty-one of these patients had non-visualizing gallbladders. Since 17 of these were over the age of 65, we may assume that these include one or more cases of carcinoma of the gallbladder. There is a tendency for many physicians to treat the so-called "sluggish gallbladder" with diet and medication and to utilize surgery as a last resort. With the asymptomatic non-visualizing gallbladder or the asymptomatic gallstone, a "don't bother it unless it bothers you" philosophy should be discouraged. The attitude "to get along with it as long as you can" may have a lethal outcome. In dealing with a carcinoma which is almost 100% fatal, but in which accompanying diseases are almost 100% diagnosable, there seems little justification for procrastination. Even if one should ignore the threat of carcinoma, it has been shown that where the gallbladder does not visualize, severity of biliary disease is greater. In an 11-year review of 781 unoperated cases of gallstone disease, severe complications, such as gangrenous cholecystitis, icterus, ileus, or carcinoma, were twice as common in patients with nonfunctioning gallbladders.[9]

In conclusion, we feel that medical staffs should be reminded that non-visualization of the gallbladder may be an ominous sign. Perhaps the surgeons who deal with these unfortunate patients must accept the responsibility for this educational effort. Admittedly, routine cholecystography in everyone over 50 is not practical, but we should be alert to the signs and symptoms of benign cholecystic disease and obtain reliable cholecystography in these patients. Prompt, appropriate surgical treatment for abnormalities detected, particularly non-visualization, is good preventive medicine. ◄

References

A complete bibliography of "The Non-Visualizing Gallbladder" may be obtained by writing *Illinois Medical Journal,* 360 N. Michigan Ave., Chicago 60601.



Edited By John M. Beal, M.D.

Cecal Volvulus

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Audiotorium at the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of March 27, 1973.

Dr. Glen Glista: An 88-year-old white woman came to the Wesley Emergency Room with a chief complaint of abdominal pain and constipation. She had a history of chronic constipation treated with enemas, suppositories and cathartics. She had not had a bowel movement during the four days before admission and developed progressively severe abdominal pain. Enemas and Dulcolax suppositories yielded poor results. About 24 hours prior to admission, nausea and vomiting appeared. Her past medical history: Three years prior to admission, she had a hysterectomy and 10 years prior to admission, removal of a benign parotid tumor. Her family history and review of systems were really noncontributory.

Physical examination: She was a cooperative elderly white woman not in acute distress. Rectal temperature 100.0°F, pulse 86 and respirations 16. Pertinent physical findings were poor skin turgor, clear sclerae, dry mucous membranes and obvious dehydration. Examination of the heart revealed a loud apical holosystolic murmur that radiated to the axilla. The abdomen was moderately distended and a well healed old scar extended from the umbilicus to the pubis. Bowel sounds were hypoactive and generalized abdominal tenderness was present without masses. Maximum tenderness was in the right lower quadrant. Rectal examination revealed an empty ampulla. Admission laboratory data included a white blood count of 11,800 with 68 polymorphonuclear leukocytes and 8 band forms and hematocrit of 42 per cent. Urinalysis was unremarkable except for a specific gravity of 1028. A BUN of 35 mg per cent and a potassium of 3.1 mEq was found. A nasogastric tube passed and returned about 500 ml of turbid fluid material. A central venous pressure line was inserted and intravenous fluids were initiated. A Fogarty catheter was placed. Dr. Nudelman will describe the X-rays.

Dr. Earl Nudelman: The initial set of films were originally taken on the 8th. There is small bowel distention and a large distended viscus in the right lower quadrant. On the 9th, there is a long air fluid level in a distended viscus and the small bowel is more distended than in the radiographs of the preceding day. (Fig. 1) The radiographic findings are compatible with a diagnosis of cecal volvulus. The barium enema confirms the diagnosis (Fig. 2). The distended viscus represents cecum. Occasionally, the diagnostic possibilities include sigmoid and cecal volvulus. The barium enema will define the correct anatomy and aid in correct pre-operative diagnosis.

Dr. Williams: We approached this patient's colon through a right perimedian incision. On entering the abdomen cavity, there was a distended loop of colon situated in the right lower quadrant; there were serosal tears due to the distention, probably, and the bowel wall and the serosa appeared reddish-gray in color. We found an area of adhesion binding down the proximal end of the ascending colon and this appeared to be the area around which the bowel volvulized.



Figure 1. Plain film of abdomen demonstrates large distended segment of bowel in the lower abdomen with small bowel distention, compatible with a diagnosis of cecal volvulus.

After carefully devolvulating it, a right colon resection was performed followed by an ileoascending colostomy.

Cecal volvulus was first reported by Rokitansky in 1841. Volvulus of the colon results from a rotation of a segment of large intestine on its mesentery, sufficient to produce partial or complete obstruction of that segment thus producing a closed loop obstruction. Varying degrees of vascular impairment result. Volvulus occurs only in a freely moveable segment of colon. About 85% of all volvulus of the colon occur in the sigmoid and 15% in the cecum.

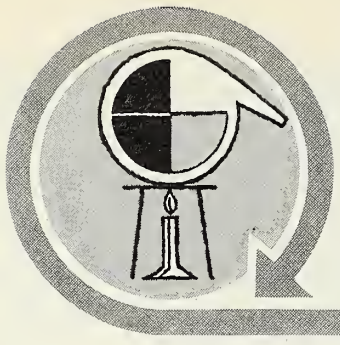
Sigmoid volvulus occurs more often in males, approximately 2 to 1, while cecal volvulus is well distributed between the sexes. Usually sigmoid volvulus is seen in older people with other conditions causing great disability. Cecal volvulus is more often seen in younger people, with an average age of approximately 40. A prerequisite for cecal volvulus is hypofixation of the cecum, which is present in 20-30% of people. Certain conditions seem to predispose to cecal volvulus, such as tumors, either in the bowel or in the peritoneal cavity, labor or pregnancy, ascites, constipation and obstructing lesions of the colon. Approximately 50% of patients with cecal volvulus have had previous intra-abdominal surgery.

When volvulus occurs in the cecum, it occurs around some fixed point. This is usually the mesenteric pedicle of the cecum, but it also can be a fibrous band across the ascending colon. Usually the rotation is 360° although 720° of rotation may occur. The twist usually occurs in a clockwise direction. The clinical picture varies depending on how rapidly the volvulus occurs. With a rapid twist and a complete vascular occlusion of the mesentery pedicle, there is sudden onset of lower abdominal pain. Pain may be continuous or crampy, and is usually associated with nausea and vomiting. These patients will look acutely and seriously ill. Abdominal distention with acute onset is variable because there is little time to accumulate gas in the small bowel. People who develop a slow volvulus or one that has little or no vascular impairment will present with signs and symptoms of small bowel obstruction. Crampy abdominal pain, marked abdominal distention, vomiting and very little tenderness is the rule. Bowel sounds will be hyperactive and high pitched. The people who have strangulated bowel have marked tenderness and rebound tenderness, usually in the right lower quadrant. Laboratory investigations are of little help as they depend on the acuteness of onset. Elevation of the white blood count and evidence of dehydration and electrolyte disturbances depend upon how rapidly the volvulus has occurred. X-ray findings are the most helpful because as it was

(Continued on page 444)



Figure 2. Barium enema shows barium entering the gas-filled distended viscus which confirms the diagnosis of volvulus of cecum.



new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions; refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

DANTRIUM	Muscle Relaxant	Rx
Manufacturer:	Eaton Laboratories	
Nonproprietary Name:	Dantrolene Sodium	
Indications:	Spasticity resulting from spinal cord injury, stroke, cerebral palsy, and multiple sclerosis.	
Warnings and Precautions:	See package insert	
Dosage:	Described in package insert	
Supplied:	Capsules, 25 and 100 mg.	
SILVADENE	Sulfonamide	Rx
Manufacturer:	Marion Laboratories	
Nonproprietary Name:	Sulfadiazine Silver	
Indications:	Adjunctive therapy for prevention and therapy of wound sepsis in second and third degree burns.	
Warnings and Precautions:	See package insert	
Administration:	Topical application to wound surface	
Supplied:	Jar, 400 gram	

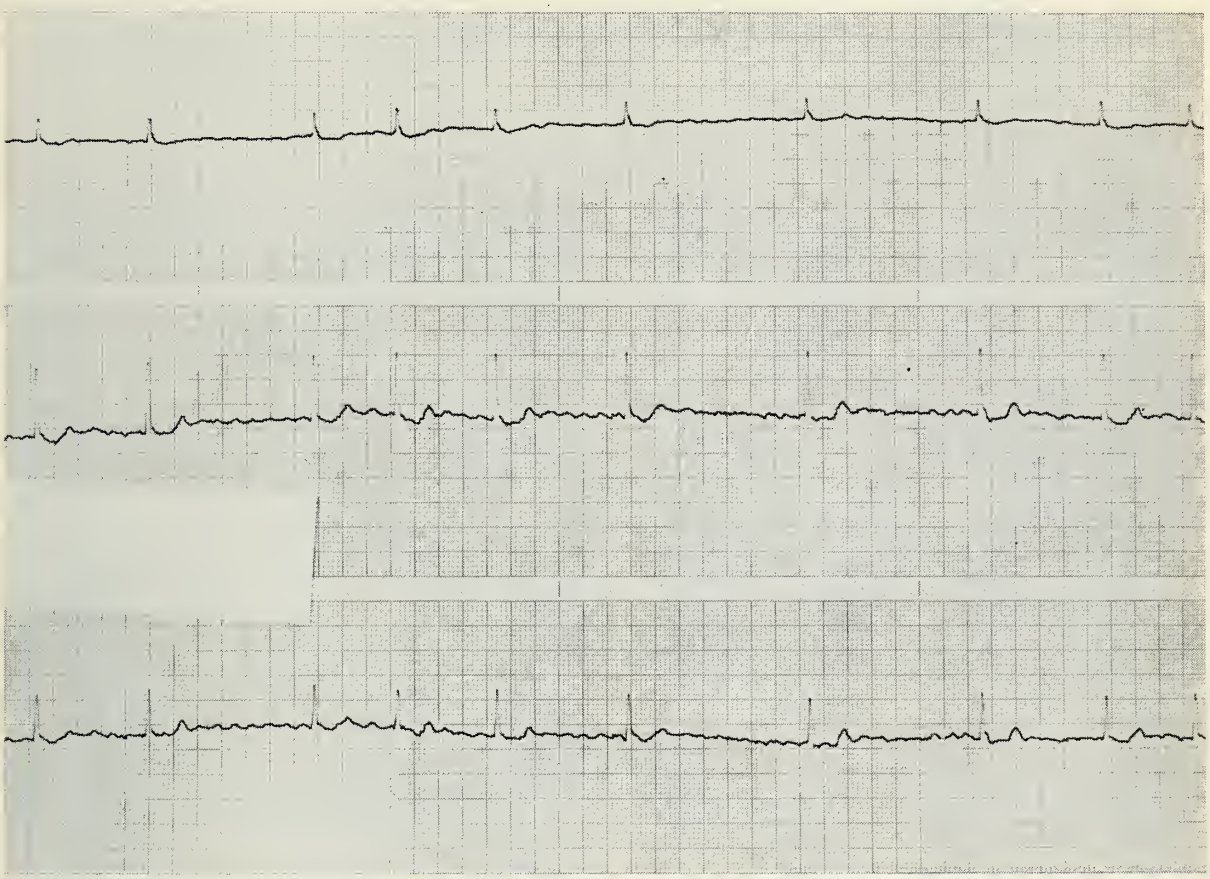
DUPLICATE SINGLE DRUGS

COMFOLAX	Fecal Softener	o.t.c.
Manufacturer:	Searle Laboratories	
Nonproprietary Name:	Dioctyl Sodium Sulfosuccinate	
Indications:	Constipation	
Supplied:	Capsules, 100 mg.	
DOWMYCIN E	Broad Spectrum Antibiotic	Rx
Manufacturer:	Dow Pharmaceuticals	
Nonproprietary Name:	Erythromycin Stearate	
Indications:	Infections susceptible to erythromycin antibiotics	
Precautions:	See package insert	
Dosage:	Adults, 250 mg every 6 hours Children, 30-50 mg/kg, consider age, weight and severity of infections.	
Supplied:	Film coated tablets, 250 mg.	
OXLAPAR	Broad Spectrum Antibiotic	Rx
Manufacturer:	Parke-Davis	
Nonproprietary Name:	Oxytetracycline HCl	
Indications:	Infections caused by susceptible organisms	
Warnings and Precautions:	Those usual for tetracycline	
Dosage:	Adults, 1 to 2 gm. daily in divided doses in 24 hours. Children, 10 to 20 mg/lb in four equal doses	
Supplied:	Tablets, 250 mg, equivalent to oxytetracycline	
PARFURAN	Antibacterial Urinary	Rx
Manufacturer:	Parke-Davis	
Nonproprietary Name:	Nitrofurantoin	
Indications:	Various forms of urinary tract infections	
Warnings and Precautions:	See package insert	
Dosage:	Adults, 50 to 100 mg. q.i.d. Children, 5 to 7 mg/kg body weight in 24 hours in divided doses	
Supplied:	Tablets, 50 mg.	
TAPAR	Analgesic	o.t.c.
Manufacturer:	Parke-Davis	
Nonproprietary Name:	Acetaminophen	
Indications:	Relief of mild pain	
Dosage:	Adults, 1 or 2 tablets t.i.d. or q.i.d. Children, 6-12 yrs, ½ or 1 tablet t.i.d. or q.i.d.	
Supplied:	Tablets, 325 mg.	
VOLEX Inj.	Plasma Expander	Rx
Manufacturer:	McGaw Laboratories	
Nonproprietary Name:	Hetastarch 6%	
Indications:	Adjunct treatment of shock due to hemorrhage, burns, surgery, sepsis or trauma requiring plasma volume expansion.	
Warnings:	Large volumes may alter coagulation mechanism	
Precautions:	Those usual with plasma expanders.	

(Continued on page 440)

ekg of the month

John R. Tobin, M.D., M.S., Rimgaudas, Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., James V. Talano, M.D., Sarah Johnson, M.D. and Rolf M. Gunnar, M.D., M.S./Section of Cardiology, Loyola University Stritch School of Medicine



A 69-year-old lady with chronic rheumatic heart disease entered the hospital in congestive heart failure. She was treated in the usual fashion and responded. This 3 lead (limb leads I, II, IV) ECG rhythm strip was taken after the lady was well digitalized and had lost approximately five pounds in weight.

Questions:

1. The ECG shows:

A. Atrial flutter with variable AV block.

B. Atrial fibrillation with slow ventricular response.

C. ST-T wave changes compatible with digitalis effect.

D. Wenckebach periodicity.

E. All of the above.

2. Further treatment should include:

A. Additional digitalis.

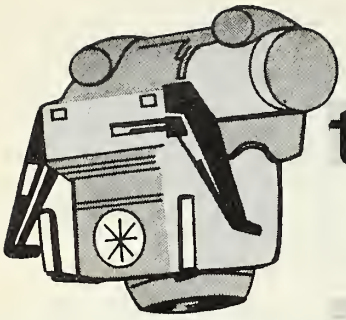
B. Consideration of a demand pacemaker.

C. Procainamide or quinidine.

D. Continued maintenance dose of digitalis.

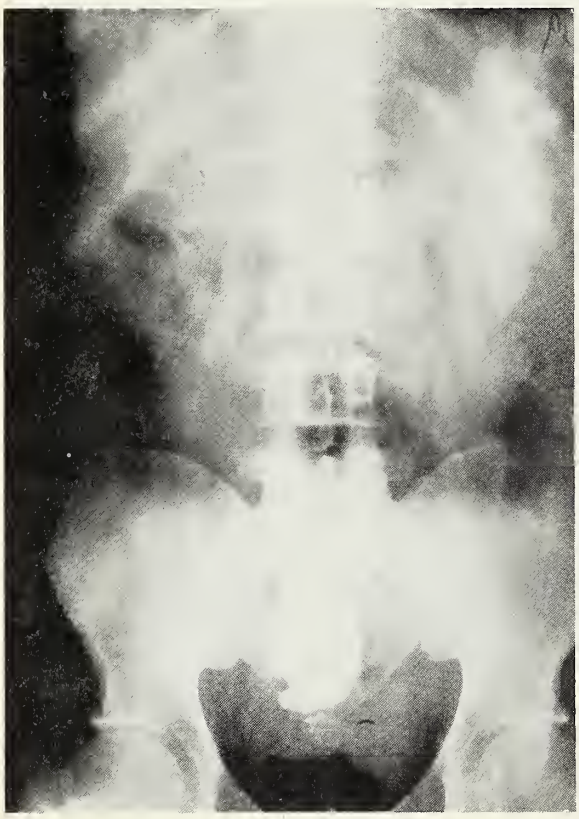
E. None of the above.

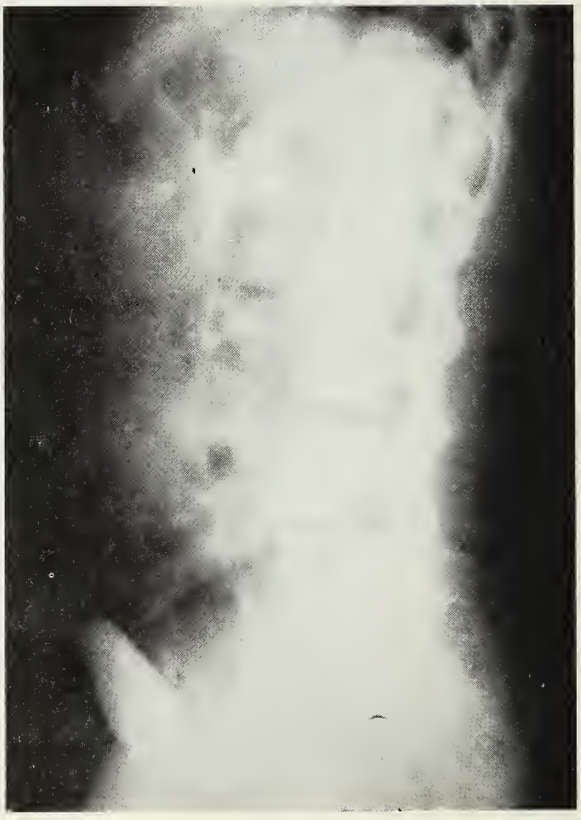
(Answers on page 450)



the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine





The patient was a 28-year-old male who complained of a mass in the projection of the lower mid-abdomen. Physical examination revealed a cyst-like mass immediately above the bladder from which fluid could be expressed through the umbilicus.

What's your diagnosis?

(Answers on 450)

Editorials



Unnecessary Surgery

Does a fat fee or a bona fide medical need determine the surgeon's decision to operate? Unnecessary surgery is a perennial complaint among politicians and those that dislike or mistrust the medical profession. Most of the unfavorable comments stem from the United States and these often are used to berate our self-insured or fee-for-service method of payment. These allegations imply that some operations are performed primarily for financial gain. Seldom are these reports accompanied by proof. In fact, rarely do they give details as to why the operation was performed (i.e., presenting symptoms and findings), even though the pathologist's report states that the appendix or uterus was normal.

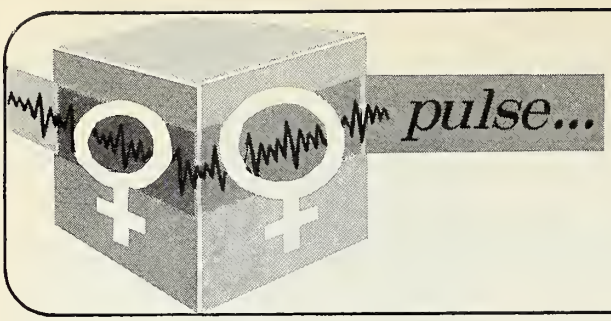
In many hospitals, including my own, the entire staff receives a complete report from the Tissue Committee. Names are provided along with the case history, the need for and findings at surgery, the pathology report, and the committee's decision. Obviously, when a surgeon's name appears too often and he makes too many erroneous diagnoses, his judgment and ability are under a cloud. In fact, his hospital appointment is jeopardized, because tenure plays no role in decisions of these types. We also are aware that the effectiveness of this approach suffers as a result of staff pressures and politics, but this situation exists in all professions, including Capitol Hill.

Some forms of surgery are very acceptable and others are controversial. We might cite operations for breast cancer, peptic ulcer, hemorrhoids, hernia, and diverticular disease. In these instances, we are less inclined to question whether a particular operation is necessary, but whether it is the best form of treatment for a particular stage of the disease.

No hue and cries are heard on ritual operations done in response to societal demands. Examples include circumcision, abortion, tonsillectomy, cosmetic (plastic) surgery, and sterilization procedures. These, in most instances, cannot be classified as lifesaving measures. Be that as it may, the decision to do or not to do an operation is up to the attending surgeon.

T. R. Van Dellen, M.D.
Editor

The June *IMJ* will commemorate 75 years of educational medical publishing by ISMS.



pulse... of the doctor's wife

MRS. HAROLD KEEGAN, Editor

Highlights of State Convention

The 46th Annual Meeting of the Woman's Auxiliary to the Illinois State Medical Society was held April 3-5, 1974, at the Conrad Hilton Hotel, Chicago. Mrs. Maynard I. (Lenore) Shaprio, Convention Chairman, and her committee, staged a successful meeting. Mrs. Robert Hartman, WA/ISMS President, presided over the House of Delegates. Featured during a house session was a talk on "Child Abuse" by James Ryan, M.D., F.A.A.P., Kankakee, and husband of WA/ISMS member. Others addressing the convention were: Roy Pfautch, Ph.D., Bertram Moss, M.D., Walter Livingston, Mrs. Robert Chapman, Mrs. Willard C. Scrivner, Elliott Partridge, M.D. and Fredric D. Lake, M.D. A more in-depth report of the convention will be featured in the first quarterly issue of *Pulse* in June.



Mrs. M. Shapiro



The new WA/ISMS President and President-elect gathered with their husbands during the annual meeting. From left to right: Dr. and Mrs. Thomas Glatter, Rockford, and Dr. and Mrs. Eugene Vickery, Lena.

Friday, April 5, 1974, the new officers of the Woman's Auxiliary to the Illinois State Medical Society were installed. Mrs. Thomas (Mickey) Glatter, Rockford, was inducted as the new president. A unique installation service was used which was written by Mrs. David Kweder (pictured at the microphone). The newly installed president's message featured communication and friendship, which was aptly illustrated by the ritual of passing salt to the person on your left.





Chatting during the Presidents' Luncheon were Mrs. Willard (Ruth) Scrivner, (left) and Mrs. Robert (Bea) Hartman. Mrs. Scrivner is the President of the Woman's Auxiliary to the American Medical Association and Mrs. Hartman was the 1973-74 WA/ISMS President.



Bob Kennedy, of Channel 7 TV, Chicago, gave an entertaining speech at the Installation Luncheon.

One of the many models from the Lord & Taylor fashion show is pictured. Theme of the fashion show was: The Message: Red, White and Blue."



New Guiding Lights



The 1974-75 WA/ISMS Board members gathered for a post-convention meeting. Pictured are, (left to right) front row: Mrs. Donald Rager, Mrs. Arnold Claycomb, Mrs. Maynard Shapiro, Mrs. Joseph O'Donnell, Mrs. August Martinucci, Mrs. N. Kenneth Furlong and Mrs. Harold Zenisek.

Second row: Mrs. Wendell Roller, Mrs. Ralph Davis, Mrs. Robert Hartman, Mrs. Thomas Glatter, Mrs. Eugene Vickery, Mrs. Edward Szewczyk, Mrs. Henry Schorr and Mrs. William Hodges.

Third row: Mrs. Alton Morris, Mrs. Richard Bowman, Mrs. Robert Webb, Mrs. Mitchell Spellberg, Mrs. Harlan Failor, Mrs. L. P. Johnson, Mrs. Joseph Shanks, Mrs. William Schowengerdt, Mrs. H. Frank Holman, Mrs. John Koenig and Mrs. George D. Wardle.

Fourth row: Mrs. Harold Keegan, Mrs. Paul Wochos, Mrs. Robert Kooiker, Mrs. Clifford Nyman, Mrs. James West, Mrs. E. F. Kortemeier, Mrs. Stanley Burris, Mrs. Frank Lippi, Mrs. Darell Statzer, Mrs. Leo Kempton and Mrs. R. S. Hoover.

Preview of National Convention

The '74 WA/AMA convention will be held at the Drake Hotel in Chicago on June 23-27. A reception will be held on Sunday evening honoring Mrs. Willard Scrivner, President WA/AMA, and Mrs. Howard Liljestrand, President-Elect. The hostesses will be the Illinois past presidents. The following days will hold many activities which include a fashion show by Bonwit Teller's; a tour of "Chicago by Nite;" a surprise evening; guest speakers, Dr. Joyce Brothers, psychologist and popular TV and radio personality; Virginia Apgar, M.D., National Foundation Vice President; and Russell B. Both, M.D., AMA president.

Another feature is the Youth Activities, held Sunday through Wednesday. A very interesting and entertaining introduction to Chicago has been planned.

The following will attend the convention as Illinois delegates: Mrs. Thomas Glatter, Mrs. Robert Hartman, Mrs. Harold Keegan, Mrs. Eugene Leonard, Mrs. Newton DuPuy, Mrs. Ed Szewdzyk, Mrs. August Martinucci, Mrs. Eugene Vickery, Mrs. John Koenig, and Mrs. Eugene Sullivan.



The Death of Moonlighting

By Michael Hughey, M.D. and Kong Meng Tan, M.D./Chicago

The "Housestaff News" is a new feature in the IMJ designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

Radical changes, including the end of housestaff moonlighting activities may occur if the report of the Committee on Goals and Priorities (GAP) of the National Board of Medical Examiners is adopted.[1] Housestaff activists have universally condemned certain aspects of the report especially that section related to granting the unrestricted license to practice medicine only after successful completion of specialty boards.

The GAP committee proposes that existing examination procedures (National Boards, FLEX, ECFMG) be eliminated and replaced by three examinations, *Qualifying A, B* and *C*. The *Qualifying A* examination would be given at the end of medical school and would "qualify" the new graduate to participate in patient care in a "supervised setting." The housestaff member would remain in this status until the completion of his entire residency training. At that point, a *Qualifying B* examination would be given. Upon successful completion of the *Qualifying B* examination, the resident would be given a license entitling him to practice medicine independent of supervision. The *Qualifying B* examination would be equivalent to the present specialty board examinations.

From time to time after his residency training, the practicing physician would be required to take a *Qualifying C* examination. It is anticipated that the *Qualifying C* examination will be administered by a council consisting of representatives of the federal government, the public, the AHA, NBME, AAMC, ABMS, FSMB, CMSS, AMA, and a proposed Liaison Committee on Continuing Education.* The practicing physician will probably be required to successfully complete *Qualifying C* or he will not be re-certified or re-licensed. The report states:

> **Periodic evaluation of professional competence will likely be required and may lead to re-certification and re-licensure if the current lifetime sanction is no longer provided.**

The basis for delaying full licensure until the completion of specialty training was stated several times throughout the report:

> **. . . medical school prepares a student for further education in a graduate training program and not for the independent practice of medicine; and, that it is the successful completion of the second phase of his education, i.e., graduate training, that readies a candidate for independent practice without supervision.**

The report also recommended special procedures for the group of physicians who either fail the examinations or elect not to take specialty training:

> **For such physicians, consideration should be given to requiring that they practice in an institutional setting under supervision until full licensure is achieved.**

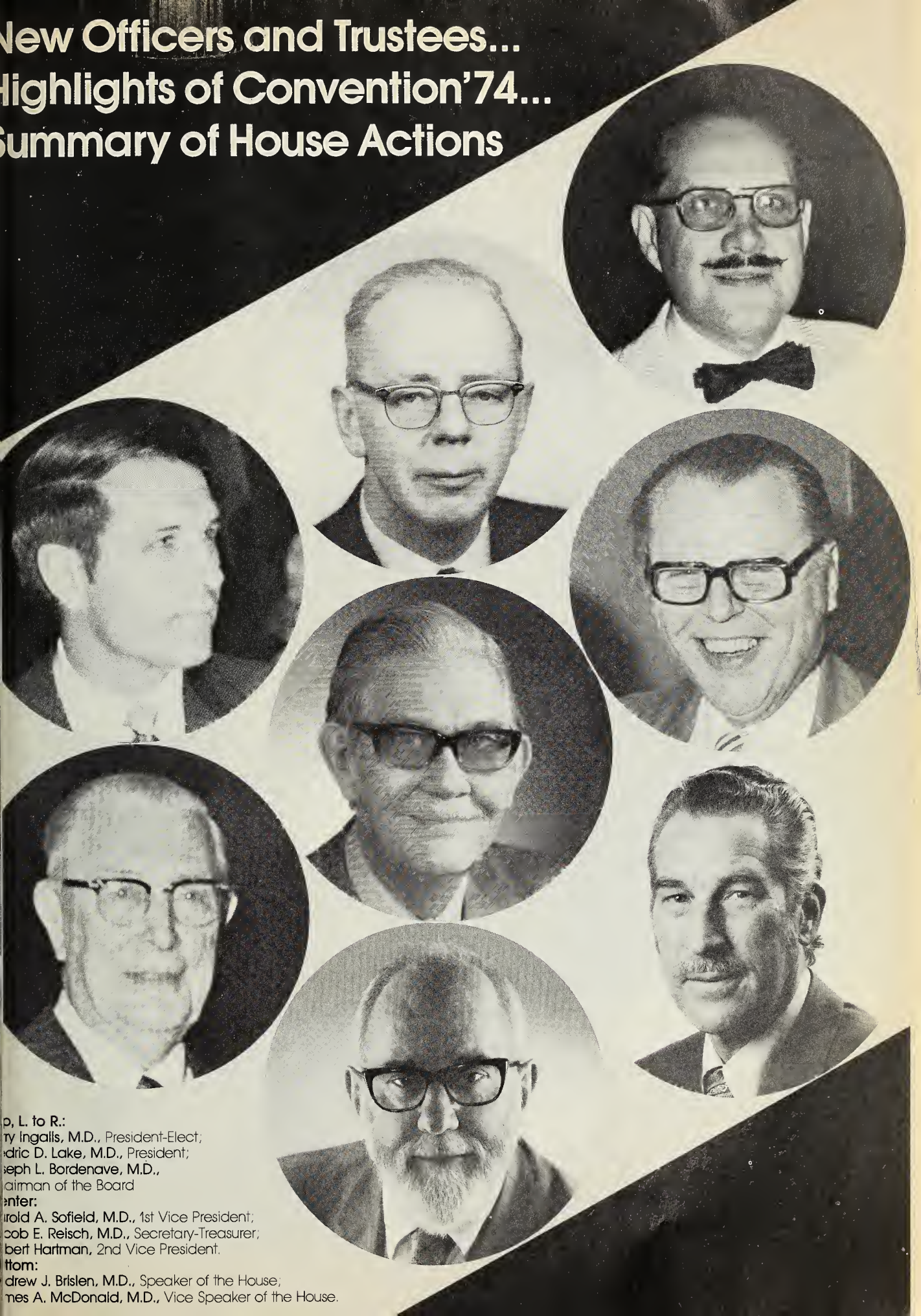
If this recommendation is adopted, housestaff members will no longer have the choice of completing their specialty training or entering private practice. Lacking the license to practice medicine they would have no alternative to remaining in a residency program to its completion.

Although the GAP committee appears to have begun its work with laudable aims in mind, its radical proposals have already stirred considerable controversy. The application of *Qualifying A* towards both foreign and domestic medical graduates appears to eliminate the current double standard whereby the foreign medical graduate must take two examinations toward licensure (ECFMG and FLEX) and the American graduate only one (National Boards). However, it appears that a pre-screening examination for foreign medical graduates is being considered, which would bring back the double standard.

(Continued on page 450)

**AHA (American Hospital Association); NBME (National Board of Medical Examiners); AAMC (Association of American Medical Colleges); ABMS (American Board of Medical Specialties); FSMB (Federation of State Medical Boards of the United States, Inc.); CMSS (Council of Medical Specialty Societies); and AMA (American Medical Association).*

New Officers and Trustees...
Highlights of Convention'74...
Summary of House Actions



p, L. to R.:
ry Ingalls, M.D., President-Elect;
edric D. Lake, M.D., President;
seph L. Bordenave, M.D.,
airman of the Board
enter:
rold A. Sofield, M.D., 1st Vice President;
cob E. Reisch, M.D., Secretary-Treasurer;
bert Hartman, 2nd Vice President.
ttom:
drew J. Brislen, M.D., Speaker of the House,
mes A. McDonald, M.D., Vice Speaker of the House.

Illinois State Medical Society 1974-75 Officers and Board of Trustees

Officers

PRESIDENT	Fredric D. Lake, 1041 Michigan Ave., Evanston 60202
PRESIDENT-ELECT	J. M. Ingalls, 502 Shaw, Paris 61944
1st VICE PRES.	Harold A. Sofield, 715 Lake Street, Oak Park 60301
2nd VICE PRES.	Robert Hartman, 1515A W. Walnut St., Jacksonville 62650
SEC.-TREAS.	Jacob E. Resich, 1129 S. 2nd Street, Springfield 62704

House of Delegates

SPEAKER	Andrew J. Brislen, 6060 S. Drexel Blvd., Chicago 60637
VICE-SPEAKER	James A. McDonald, 13 S. 2nd Street, Geneva 60134

Trustees

1st District	1977	Joseph L. Bordenave, 1665 South St., Geneva 60134
2nd District	1977	Allan Goslin, 712 N. Bloomington, Streator 61364
3rd District	1976	David S. Fox, 20829 Greenwood Center Ct., Olympia Fields 60461
	1976	Robert T. Fox, 2136 Robin Crest, Glenview 60025
	1975	Eugene T. Hoban, 6429 W. North Ave., Oak Park 60302
	1977	William M. Lees, 6518 N. Nokomis, Lincolnwood 60646
	1977	George Shropshear, 1525 E. 53rd, Chicago 60615
	1975	Joseph H. Skom, 707 N. Fairbanks Ct., Chicago 60611
	1977	Philip G. Thomsen, 13826 Lincoln, Dolton 60419
	1976	Fredrick E. Weiss, 15643 Lincoln, Harvey 60426
	1975	Warren W. Young, 3450 Haweswood Dr., Crete 60417
4th District	1976	Fred Z. White, 723 N. 2nd St., Chillicothe 61523
5th District	1976	A. Edward Livingston, 326 Fairway Dr., Bloomington 61701
6th District	1975	Mather Pfeiffenberger, State and Wall Sts., Alton 62002
7th District	1976	Arthur F. Goodyear, 142 E. Prairie, Decatur 62523
8th District	1976	Eugene P. Johnson, P.O. Box 68, Casey 62420
9th District	1975	Warren D. Tuttle, 203 N. Vine St., Harrisburg 62946
10th District	1975	Herbert Dexheimer, 301 S. Illinois, Belleville 62220
11th District	1977	Ross Hutchison, 126 E. 9th St., Gibson City 60936

Trustee-At-Large Willard C. Scrivner, 6600 W. Main, Belleville 62223

Chairman of the Board Joseph L. Bordenave, 1665 South St., Geneva 60134

HIGHLIGHTS OF CONVENTION



President's Night Honors Willard C. Scrivner, M.D.

Willard C. Scrivner, 1973-74 ISMS President, was honored at the annual President's Night. His wife, Ruth, also received recognition for her efforts in organized medicine. Mrs. Scrivner, is the President of the Woman's Auxiliary to the AMA. Pictured above: Jacob E. Reisch, M.D., presenting Dr. and Mrs. Scrivner with a plaque of appreciation; looking on is Frank J. Jirka, Jr., M.D., Master of Ceremonies for the event.



Fredric D. Lake, M.D., Installed as New ISMS President



The new ISMS First Lady, Mrs. Fredric D. Lake.

During the final session of the ISMS House of Delegates, Fredric D. Lake, M.D., Evanston, was inducted into office of Presidency by retiring President, Willard C. Scrivner, M.D.





Dr. and Mrs. Lake are pictured with two of their four children at the installation.

Over 4,000 Attend Convention and Clinical Conference

The 134th Annual Meeting of the Illinois State Medical Society and the Midwest Clinical Conference drew an attendance of over 4,000 physicians, Woman's Auxiliary, Medical Assistants, exhibitors, medical students and visitors. Over half of the attendees were Illinois physicians.

House of Delegates Attendance

The Committee on Credentials reported the following attendance during the 134th Annual Meeting of the Illinois State Medical Society:

	Officers	Trustees	Speaker Vice Speaker	Downstate	Cook County	SAMA
First Session						
50 counties	4	19	2	74	74	1
Second Session						
55 Counties	4	18	1	78	58	1
Third Session						
49 counties	5	18	2	71	68	1

AMA Delegation Introduced

Carl E. Clark, M.D., Chairman of the ISMS Delegation to the American Medical Association, introduced the delegates and alternates to the House of Delegates. Dr. Clark reported that the AMA Delegation is supporting the candidacy of Frank J. Jirka, Jr. M.D., to be an AMA Trustee.

Current delegates to the AMA are: Drs. Jack Gibbs, Theodore Grevas, H. Close Hessletine, Maurice Hoeltgen, Frank Jirka, William M. Lees, Morgan Meyer, Edward Piszczek, Philip G. Thomsen, Theodore R. VanDellen and Charles K. Wells. Alternates are: Drs. Herschel Browns, Alfred Faber, Allison Burdick, Jr., J. M. Ingalls, Fredric Lake, Eugene Leonard, Joseph O'Donnell, George Shropshear, Paul Sunderland, Glen Tomlinson and Fred Tworoger.

Executive Administrator Expresses Concern Over PSRO

Roger N. White, ISMS Executive Administrator, expressed concern over PSRO breaking the back of organized medicine. Mr. White pointed out that the present structure of 91 county medical societies would be obsolete if the Federal government divided Illinois into the proposed 8 PSRO regions.

The Executive Administrator also praised the efforts and work of the ISMS officers, trustees and staff during the past year.



AMA/ERF Check Presented For Illinois Medical Schools

During the ISMS annual meeting, ISMS President Willard C. Scrivner, M.D., (pictured above) presented a check for $204,616.17 to Joseph A. Wells, M.D., Dean of Loyola University's Stritch School of Medicine and member of the Illinois Council of Deans.

The American Medical Association Education and Research Foundation Program distributes the funds to medical schools throughout the United States. These noted during the Annual Meeting represent 1973 contributions from Illinois.

A breakdown of the amounts for the Illinois schools are:

Northwestern University Medical School, $41,921.23
University of Illinois College of Medicine, $40,670.42
Stritch Medical School, Loyola University, $36,220.90
Chicago Medical School, $27,956.04
Rush Medical College of Chicago, $19,300.66
Pritzker School of Medicine of the University of Chicago, $17,485.71
Southern Illinois University Foundation, $11,052.03
Peoria School of Medicine, $5,168.06
Rockford School of Medicine, $4,841.12

IMPAC Needs Full Support of Physicians

In his report to the House of Delegates, Fred Tworoger, M.D., Chairman of IMPAC, pointed out the importance of full participation of the membership to make IMPAC (Illinois Medical Political Action Committee) strong. He noted the increase in the Woman's Auxiliary membership upon the opening of the family membership program. During 1974 there was an increase from 53 to 2,465 Woman's Auxiliary members.

Dr. Tworoger briefly outlined the utilization of IMPAC dollars. Voluntary dollars are allocated to candidates in both parties who are deemed deserving of such contributions. The decision as to the amount is made by the IMPAC Board of Directors.

Health Care Conference Featured Caspar Weinberger, HEW Secretary



Caspar Weinberger, HEW Secretary with Willard C. Scrivner, M.D.

"I am here today to assure you that I intend to see—to the very best of my ability—that your talent and dedication which have served so many people so well, are not abused, overused or curtailed by any excessive Federal controls on the practice of medicine," stated Caspar Weinberger in his opening remarks to the Conference on Surgi-Centers, HMO's and PSRO, April 3, 1974, at the Conrad Hilton.

Mr. Weinberger, Secretary of Health, Education and Welfare, was one of the many guests at the conference which preceded the 134th ISMS annual meeting and the Midwest Clinical Conference. Joseph R. O'Donnell, M.D., Chairman of the ISMS Committee on Health Care Financing served as the moderator.

Subjects and speakers for the conference included:

Ambulatory Surgery—The Concept,
Herbert Natof, M.D.
The Free Standing Surgi-Center,
Richard Schultz, M.D.
The Hospital Viewpoint, Mr. E. Winn Presson
What in Health is an HMO—Why Now?
Mr. Leon Felson
Legislative Update, Paul B. Batalden, M.D. and Sen. Jack T. Knuepfer
HMO's In Illinois—A Progress Report, Audley F. Connor Jr., M.D.; Mr. Hilmon S. Sorey, Jr.; Robert P. Johnson, M.D.; and Roy J. Philipp, M.D.
Impact on Rural Practice,
Mack W. Hollowell, M.D.
PSRO-Quality Care Assessment:
PSRO Upate, Willard C. Scrivner, M.D.
National Developments,
James H. Sammons, M.D.
The Illinois Alternative,
William M. Lees, M.D.
The Hospital Viewpoint,
Mr. Peter Goschy

Mr. Weinberger briefly outlined the proposal for a Comprehensive Health Insurance Plan (CHIP) which is based on a partnership between the Federal Government and the private health care system. He pointed out the significance of this program having the Health Card which means that the insurance carrier would pay in full the hospital bill and most doctors' fees immediately, then bill the patient the difference.

"We recognize that the Federal Government cannot and should not be in the position of reviewing and monitoring the quality of care which physicians provided their patients. Only physicians can judge the appropriateness and quality of care," claimed Weinberger concerning the controversial PSRO issue.

Past Presidents Gather For Gourmet Dinner



On the eve of the ISMS annual meeting, 10 past presidents gathered for a gourmet dinner. Charles J. Jannings, III, M.D., served as Masters of Ceremonies. The past presidents paid tribute to Frank J. Jirka, Jr., Immediate Past President. Jacob E. Reisch, M.D., Secretary/Treasurer, served as host for the affair.

Front row: (from left to right) Edward Piszczek, M.D.; Caesar Portes, M.D.; Arkell Vaughn, M.D.; Leo P.A. Sweeney, M.D.; and E. P. Coleman, M.D.

Standing (from left to right) Philip Thomsen, M.D.; Jacob E. Reisch, M.D.; Frank J. Jirka, Jr., M.D.; Charles J. Jannings, III, M.D.; Newton DuPuy, M.D.; and J. Ernest Breed, M.D.

Fifty-Year Club Honors 66

The annual luncheon of the Fifty-Year Club honored 66 new members April 5, 1974. Paul W. Sunderland, M.D., Chairman of the Fifty-Year Club, presented the awards to Illinois physicians who are ISMS members and have been practicing physicians for 50 years. Over 600 physicians are now members of this elite group. Some 120 persons, including members previously inducted, were in attendance.

"Memories and Reflections" was the topic of the guest speaker, Morris Fishbein, M.D., Editor, *Medical World News.*



Dr. Fishbein

Congressman Railsback Speaker at Public Affairs Breakfast

Over 250 physicians, wives, Woman's Auxiliary members and guests heard U.S. Congressman Tom Railsback speak at the Public Affairs Breakfast, April 5, 1974.

Congressman Railsback informed the group of the investigation for impeaching the President. He serves on the judiciary committee that is probing the issue.

"Politics Effect on Physicians" Theme of AMA Officer's Speech



Dr. Todd

Malcolm Todd, M.D., President-Elect of the American Medical Association, was a guest speaker at the opening session of the 134th ISMS annual meeting. Dr. Todd's theme was "Politics' Effect on Physicians."

The AMA officer feels since there is more government involvement in health care, there needs to be more physicians involved in politics.

On the subject of PSRO, Dr. Todd said he didn't blame the ISMS House of Delegates for opposing the law. He cited that the AMA is presently drafting 18 amendments to the PSRO Law.

"Medicine will work with government, but *not* for the government," acclaimed Dr. Todd. He feels that the government is more concerned over the cost control of medicine, where medicine is more concerned over quality of health care.

Dr. Todd will be installed as the President of the AMA in June at the annual AMA Convention to be held in Chicago. He is a graduate of Northwestern University Medical School.

Willard C. Scrivner, M.D., Honored At President's Night



Willard C. Scrivner, M.D., 1973-74 President of ISMS, was honored at President's Night, April 4, 1974, at the Conrad Hilton Hotel, Friends, medical colleagues, Woman's Auxiliary and ISMS members gathered for the gala evening to pay tribute to the Belleville obstetrician and gynecologist. Frank J. Jirka, Jr., M.D., Immediate Past President, served as Master of Ceremonies for the evening.

Also receiving praise was the First Lady of ISMS, Mrs. Willard (Ruth) Scrivner. Mrs. Scrivner is President of the Woman's Auxiliary to the American Medical Association. In attendance for the evening were Dr. and Mrs. Scrivner's sons, Roger and Peter, and their wives.

The Public Relations Council of ISMS presented Dr. Scrivner with a scrapbook outlining his past year's activities and President's Tour.

Also recognized were Malcolm Todd, M.D., President-Elect, AMA; James Sammons, M.D., Executive Vice-President of AMA; Mrs. Robert (Beatrice) Hartman, President of the Woman's Auxiliary to ISMS and Mrs. Norma Domanic, President of the Illinois Society, American Association of Medical Assistants. The Presidents of the Indiana and Michigan Medical Associations, the Illinois Dental Society and the Illinois Pharmaceutical Association also were in attendance.

INTRAV hosted a pre-dinner social hour. Entertainment for the evening included "The First Nighters" and music by Hal Kartun and his orchestra.

Active Year For Medical Assistants

Norma Domanic, President, Illinois Society of the Association of American Medical Assistants, told the ISMS House of Delegates of the active year of the medical assistants in her annual report. During the year there were nine travel courses and 13 government workshops made available for technicians, nurses and bookkeepers. Subjects of these courses and workshops included malpractice, lab services, Medicare, Medicaid and Champus.



Mrs. Domanic

There are presently 30 active chapters in the Illinois Society of AAMA. Mrs. Domanic asked physicians to advise it of any needed assistance in setting up chapters in other areas. She offered her praise and gratitude to ISMS staff and advisory committee for assistance during the year.

Dr. Scrivner Reviewed His "Program of Progress"

"One of the most gratifying experiences of this past year was the response of doctors, news media and the public to the 'Physicians Bill of Rights'," stated Willard C. Scrivner, M.D., retiring ISMS President, during his address to the opening session of the 1974 House of Delegates. The Bill of Rights, authored by Dr. Scrivner, was drafted for safeguarding the practice of medicine from increasing third party and governmental interference.

In his remarks, Dr. Scrivner reviewed his Program of Progress as outlined one year ago with the formula of UNITY + STRENGTH = EFFECTIVENESS (USE). He emphasized his appreciation for the recent decision of the ISMS delegates to take a unified stand against PSRO (PL92-603)—seeking instead a statewide program which best suits the needs of Illinois physicians and which will be superior to any government program.

Dr. Scrivner reported progress in providing health care to the poor. Last spring, a conference on Health Care of Poor brought ISMS together with the Council on Community Services in Metropolitan Chicago. The efforts of the two groups has established a health and social service referral "Hot Line" which eventually will operate 24 hours a day.



Dr. Scrivner

"I have never been prouder of my profession and my colleagues in ISMS than just a few weeks ago, when ISMS offered the services of volunteer physicians and staff to speed a state investigation into the quality of care given by doctors who treat large numbers of welfare patients in the Chicago area," acclaimed Dr. Scrivner while encouraging physicians to exert leadership in guaranteeing quality care.

In closing, Dr. Scrivner expressed appreciation for the opportunity to serve as "ISMS President, servant and spokesman," regretting only that the year went by too quickly.

Auxiliary Increases Membership



Mrs. Hartman

Mrs. Robert Hartman, President of the Woman's Auxiliary to the Illinois State Medical Society, reported to the House of Delegates that there had been an increase of 302 new members during the past year.

She reviewed the success of the Health Education Symposium, co-sponsored by the Auxiliary and ISMS, indicating anticipation that this event will become an annual project. In promoting safety, the Woman's Auxiliary is distributing Mouth-to-Mouth Resuscitation Plaques for display at swimming pools in Illinois. An outstanding county project for the year comes from Kankakee, which is a program for approaching drug abuse.

The Auxiliary contributed over $12,500 to the AMA/ERF Fund and over $2,635.00 to the Benevolence Fund in 1973.

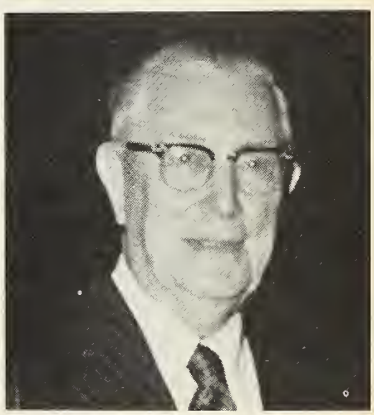
Nine Auxilians served on ISMS Councils and Committees during the past year.

Mrs. Hartman reported that her theme of *"Ad Astra Per Aspera"* (To the Stars Through Aspirations) had been carried out in her monthly letter to the Board members with an attached copy of "Pulse" from the *Illinois Medical Journal.*

In conclusion, the WA/ISMS President reported that the Auxiliary appreciated the assistance of the ISMS to help achieve the Auxiliary's goals for the year, happily reporting "Mission Accomplished."

Harold A. Sofield, M.D. Receives Hamilton Teaching Award

The 1974 Edwin S. Hamilton Interstate Teaching Award was presented to Harold A. Sofield, M.D., emeritus professor of orthopedic surgery at Northwestern University Medical School. Dr. Sofield received a plaque and honorarium from Mather Pfeiffenberger, M.D., Alton, ISMS Trustee and Trustee, Interstate Post Graduate Medical Association of North America.



Dr. Sofield

Dr. Sofield is currently authoring a textbook on pediatric orthopedics. He serves as consultant to the Shriner's Hospital for Crippled Children and to the Surgeon General. Dr. Sofield has led an active role in organized medicine and is a former president of the Chicago Medical Society, Chicago Orthopedic Society, American Academy of Orthopedic Surgery and American Board of Orthopedic Surgery.

He is an ISMS delegate to the American Medical Association, the new First Vice President of ISMS, and serves on the ISMS Medical-Legal Council.

The award has been given for the past eight years in recognition of Edwin S. Hamilton, M.D., Kankakee, who has been active in the postgraduate group and is a former ISMS President. The ISMS Council on Education and Manpower selects the recipient of this award, which is sponsored by IPMANA.

"Double Trouble" For Illinois Physicians

In his inaugural speech as new ISMS President, Fredric D. Lake, M.D., profoundly disclosed the "double trouble" of the Illinois physicians with the threat of federal government, and more importantly, an internal dilemma.

He called for a close look at the governance and structure of organized medicine in Illinois as well as means to attract the interest of younger physicians and generate participation in the society.

In his address Dr. Lake asked for a special committee, and subcommittees if necessary, to study and evaluate the structure of ISMS. (Action was later taken on this matter by the House.)

Dr. Lake outlined his goals for the coming year as President:

- to endeavor and to heal wounds;
- to heighten the interest of academia and of the specialty societies in organized medicine;
- to awaken the dormant interest of a large portion of membership in the affairs of the society and to bring the members to a realization that only through concerted action and harmony can medicine successfully ward off many threats to freedom; and
- to support to the best of his ability the goals and purposes of this great society.

House Sets Up Special Committee To Study Internal Organization and Operations Of ISMS and Relationships With Other Societies

Acting upon the request and by a special resolution presented by newly installed ISMS President, Fredric D. Lake, M.D., the House of Delegates voted to set up a House committee to study the internal organization and operation of ISMS and to evaluate redistricting and tenure of trustees. In addition, attention will be given to the various relationships with other societies.

The committee will be chaired by the President-Elect and consist of not less than seven members. The Speaker of the House was designated to appoint the members.

New Officers and Trustees Elected

New officers of the Illinois State Medical Society were elected in the final session of the 134th Annual Meeting.

Elected officers for 1974-1975 were:

President-Elect: J. M. Ingalls, M.D., Paris
1st Vice President: Harold A. Sofield, M.D., Oak Park
2nd Vice President: Robert Hartman, M.D., Jacksonville
Secretary/Treasurer: Jacob E. Reisch, M.D., Springfield
Speaker of the House: Andrew J. Brislen, M.D., Chicago
Vice Speaker of the House: James A. McDonald, M.D., Geneva

Trustees elected for three-year terms were:

First District:	J. L. Bordenave, M.D., Geneva
Second District:	Allan Goslin, M.D., Streator
Third District:	William M. Lees, M.D., Lincolnwood
	George Shropshear, M.D., Chicago
	Philip G. Thomsen, M.D., Dolton
Eleventh District:	Ross Hutchison, M.D., Gibson City

Continuing Medical Education Programs Recognized

During the 1974 House of Delegates meeting, recognition certificates of accreditation were given to seven threat of Federal government, and more importantly, continuing medical education programs accomplished in Illinois. Receiving accreditation through the Illinois State Medical Society, which is responsible for reviewing intrastate programs, were:

FAB³/CME (Forkosh Memorial, American, Bethany Methodist, Bethesda and Belmont Community Hospitals)
Martha Washington Hospital
Oak Park Hospital
Memorial Hospital of DuPage County
Community Hospital of Geneva
DuPage County Medical Society
Illinois Council on Continuing Medical Education

DuPage County Medical Society is the first county society in the nation to receive CME accreditation through the state society. Illinois now has two counties with accreditation, the Chicago Medical Society having been certified previously by the American Medical Association.

Reference Committees Prepare Reports for House Approval

The second and third sessions of the 1974 ISMS House of Delegates heard reports of eight reference committees which met opening night and into the early morning hours preparing reports for the House. Each committee listened to comments on assigned resolutions and reports, and then met in executive session to draft the report.

Serving as chairmen of reference committees were:

Governmental Affairs and Medical Legal
Theodore Grevas, M.D.

Economics, Peer Review, Social and Medical Services
John Ovtiz, M.D.

Amendments to the Constitution and Bylaws
James Laidlaw, M.D.

Environmental, Community and Mental Health
Vincent C. Sarley, M.D., J.D.

Officers and Administration
John Ring, M.D.

Public Relations, Membership and Miscellaneous Business
Lawrence Hirsch, M.D.

Finances, Budgets and Publications
C. Otis Smith, M.D.

Education and Manpower
David T. Petty, M.D.

AMA Delegation Elected

One of the final actions of the 1974 ISMS House of Delegates was to elect members of the delegation to the American Medical Association. Elected to take office January 1, 1975, and serve until December 31, 1976, were: Carl E. Clark, M.D., Sycamore; H. Close Hesseltine, M.D., Chicago; Maurice M. Hoeltgen, M.D., Chicago; Alfred J. Faber, M.D., Glenview; Charles K. Wells, M.D., Mt. Vernon; and William M. Lees, M.D., Lincolnwood.

Alternate delegates elected to serve from January 1, 1975, until December 31, 1976, were: Theodore R. Van Dellen, M.D., Chicago; Fredric D. Lake, M.D., Evanston; Eugene T. Leonard, M.D., Rockford; John Ring, M.D., Mundelein; and Fred Tworoger, M.D., Chicago.

Summary of Actions of the 1974 House of Delegates

I. AMENDMENTS TO CONSTITUTION AND BYLAWS

The House amended the bylaws to:

A. Specify that candidates for in-training membership must be members of a component medical society and need not have other recommendation for ISMS membership.

B. Eliminate SAMA membership as a prerequisite for student membership in ISMS.

C. Make the dues delinquency date compatible with that of the AMA by requiring each county medical society to pay its assessment to ISMS by March 31 of each year. The House also directed the Committee on Constitution and Bylaws to prepare appropriate amendments to clarify chapters of the bylaws dealing with dues of members and assessments of component societies.

D. Discontinue the 50% dues reduction granted to academic physicians.

E. Eliminate the Committee on Committees as a standing committee of the Board of Trustees.

F. Give the Council on Economics and Peer Review the power to review both the procedural and substantive aspects of any appeal.

G. Allow physician employees of the AMA and others who may be licensed in a state or territory other than Illinois to become regular members of ISMS. Previously, AMA employees were classified as Service Members.

H. Provide for an intern/resident delegate and alternate delegate in the ISMS House of Delegates.

In order to provide guidance for the Committee on Constitution and Bylaws in drafting appropriate amendments for next year, the House ordered the Board of Trustees to reactivate the Committee on Redistricting and Tenure.

II. REPORTS OF OFFICERS AND ADMINISTRATION

The House reaffirmed the ISMS abortion policy established last year by rejecting two resolutions calling for a change in policy.

Also reaffirmed was a statement on confidentiality, indicating that ISMS supports Section 9 of the Principles of Medical Ethics while recognizing the need for collection of statistical data and enforcement activities in the public good.

Action was deferred on an amended resolution requiring that all component societies of ISMS and their sponsored organizations be reminded that their affiliation carries with it the irrefutable responsibility to act in unity with and in support of the ISMS Board of Trustees in carrying out the policies of the House of Delegates.

A proposal to establish a 1-A trustee district in the northwest part of the state was referred to the Board of Trustees for study with instructions to report its findings and recommendations to the 1975 House of Delegates.

The House also authorized the Board of Trustees, if and when needed, to initiate direct legal action by suit or otherwise—or indirect action as a friend of the court in suits initiated by others—either in support of the ISMS alternative program to PSRO or to prevent action by federal officials or others in regard to implementation of the federal PSRO program.

III. FINANCES, BUDGETS AND PUBLICATIONS

The House approved the following dues structure for 1975:

Operating fund	$105
AMA-ERF	10
Illinois Council on Continuing Medical Education	10
Benevolence	5

Assessment for liaison activities with students, interns and residents	1

	$131

Dues for interns and residents were lowered from $10 to $5 per year and for medical students from $10 to $2 per year, beginning in 1975.

A proposal to provide the president, president-elect and chairman of the Board of Trustees with honoraria during their terms of office was amended to authorize the Board to increase per diem allowance of officers if necessary.

The House also voted an immediate assessment of $25 per member to conduct an ongoing campaign relative to the deleterious effects of PSRO and other objectionable regulatory control portions of P.L. 92-603 and to provide start-up funds for a new statewide medical review program.

The House reviewed the actions of its February 24 special session and approved the following actions currently being implemented under the guidance of the ISMS Executive Committee and the interim Board of Directors of the Illinois Professional Standards Review Organization:

A. Educational Programs—"Action Report," personal contact, testifying at PSRO hearings in Washington, tent cards for physician's offices, envelope stuffers, print and broadcast advertising, newspaper stories and editorials, radio-TV programs, and the platforms of community groups will be utilized to reach ISMS members, legislators, patients and the general public at an estimated cost of $123,300.

B. Illinois Alternative to PSRO—The Illinois Professional Standards Review Organization will be developed as a consortium of representatives of the hospital association, nursing homes, the Illinois Department of Public Aid, Comprehensive Health Planning, Health Insurance Council, Blue Cross-Blue Shield, doctors of medicine and osteopathy. Using the Hospital Admission and Surveillance Program as a prototype, IPSRO will devise overall guidelines and make necessary administrative arrangements to create a unified program of institutional review throughout Illinois with these reviews done through local medical review organizations formed by physicians in geographic areas.

C. Financing—Each member is to be assessed $25 to pay the cost of the educational campaign, and the start-up funds for local medical review organizations, and possibly to support legal action if an overt attempt is made by the federal government to prevent implementation of the voluntary alternative plan.

In a separate action, the House directed that a feasibility study be made to determine the interest of Illinois physicians in the formation of Health Maintenance Organizations and that ISMS re-examine its position on the use of federal funds, grants, etc., in the development of its programs involving peer review and criteria standards.

IV. ECONOMICS, PEER REVIEW, SOCIAL AND MEDICAL SERVICES

The House took the following actions affecting the economic aspects of medical practice:

A. Directed the AMA Delegation to request the American Medical Association to develop a policy statement on the billing for services performed by ancillary personnel employed by the physicians.

B. Redefined alcoholism; urged ISMS to encourage insurance companies to include appropriate coverage for alcoholism in health insurance policies; and encouraged general hospitals to accept alcoholic patients for detoxification and rehabilitation.

C. Rejected a proposed set of principles on The Relationship of Medical Diagnosis to Prognosis and Treatment as being already covered in existing policies of ISMS or the Illinois Foundation for Medical Care in its HASP program.

D. Condemned as injurious and discriminatory the federal regulations denying Medicare coverage for psychiatric overnight therapeutic test home visit treatment measures to the elderly and disabled.

E. Approved the concept of the Early Periodic Screening Diagnosis and Treatment Medicheck Program provided: it has annual approval of the county medical society and participation of the majority of local primary care physicians; it is under the direct control of peer review and ethical relations committees of the county medical society; and payments conform to usual and customary fees. County societies currently participating in pilot projects, however, are encouraged to continue to operate and collect data for possible amendment to the Act.

F. Rejected a proposal to withdraw support from Illinois Blue Shield; instead the House commended Blue Shield for its policies and operational activities.

G. Overwhelmingly supported AMA requests to the Cost of Living Council to remove control of physician's fees.

H. Directed ISMS to encourage all major health insurance carriers to utilize the new AMA health insurance claim form.

I. Urged ISMS to request the Illinois Department of Public Aid to provide itemized receipts with prompt physician payment.

J. Directed that: (1) the AMA's CURRENT PROCEDURAL TERMINOLOGY be used as the code in developing a new Relative Value Study; (2) the RVS be sequentially arranged by code and include a procedural index; (3) the basic RVS unit value be based on a routine office visit; and (4) that $16,650 be borrowed from the Educational and Scientific Foundation to pay production costs of a new RVS.

K. Adopted a four-point statement dealing with governmental health care programs and commercial third-party payors. The policy statement: (1) authorized a contract with the Illinois Foundation for Medical Care to employ skilled professional negotiators to represent all practicing physicians in their relationships with the Illinois Department of Public Aid; (2) instructed the ISMS Board of Trustees to utilize IFMC as agent for all statewide governmental health care programs (federal and state) and commercial third-party carriers without pre-empting contracts negotiated by affiliated local FMCs; (3) urged ISMS members to submit documentary evidence to IFMC supporting complaints against any third-party payor; and (4) directed that all contracts include the concepts of freedom of choice for physician and patient, fee-for-service, and usual and customary fees.

L. Called for the Legislative Advisory Commission on Public Aid to conduct an investigation of IDPA and its reimbursement procedures for medical services. The board of Trustees was directed to organize a blue ribbon panel of practicing physicians to work closely with the legislative commission to insure that medicine has input into this investigation.

M. Commended the AMA Board of Trustees and its Advisory Council on PSRO for its efforts to institute an ongoing campaign to inform legislators and the public of the deleterious effects of the PSRO law as it relates to quality of patient care, finances, and confidentiality.

V. EDUCATION AND MANPOWER

Pointing out the society's long-standing opposition to dual standards of health care for Illinois citizens, the House rejected a resolution calling for modification of the law which will eliminate the hospital "permit" physician in June, 1975.

Addressing itself to the alcoholism problem, the House: (1) encouraged medical schools and hospitals to expand training programs on the cause and treatment of alcoholism; (2) urged mental health clinics to include treatment of alcoholics and counseling for their families; and (3) encouraged development of educational programs aimed at alcohol abusers, as well as the general public.

As a step toward improving relationships between hospitals and physicians, the House urged county medical societies to provide representation for hospital medical staffs on the executive committee or council of each society. It also directed ISMS to develop means by which local societies can become more effective spokesmen for physicians individually and collectively in their dealings with hospitals and other health care providers.

Referred to the Board of Trustees was a report of the Council on Education and Manpower indicating that a liaison committee formed to maintain close communications with the Council of Deans was not active and communications not established. The Board was asked to intervene on behalf of the council to establish this liaison.

VI. ENVIRONMENTAL COMMUNITY AND MENTAL HEALTH

The House indicated its opposition to the sale of

tobacco in hospitals and recommended medical staff action to make hospitals tobacco smoke-free.

A definition of medical psychotherapy developed by the Council on Mental Health and Addiction was referred back to the council for refinement. The Board of Trustees was authorized to accept an improved version for publication in the Policy Manual.

VII. PUBLIC RELATIONS, MEMBERSHIP AND MISCELLANEOUS BUSINESS

The House urged all physicians to report instances of medical prescription misuse to their county medical society and appropriate law enforcement agencies; county medical societies will be encouraged to report such documented instances to ISMS and the Department of Registration and Education.

In a related action, the House approved the concept of a medical disciplinary system in Illinois and authorized the Board of Trustees to have appropriate legislation prepared for introduction in the General Assembly.

Also adopted was a policy indicating that health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all its branches and interpretation of the appropriateness and reliability of various screening procedures used.

Stating that the AMA Public Affairs Division does not have direct physician input at the grass roots level, the House instructed the Illinois Delegation to the AMA to introduce a resolution at the June, 1974, annual meeting urging AMA to form a Public Affairs Committee made up of physicians.

VIII. GOVERNMENTAL AFFAIRS AND MEDICAL-LEGAL

The House took the following action on legislative and medical-legal proposals:

A. Rejected a plan for creating a separate chiropractic examining committee on which physicians and surgeons licensed to practice medicine in all its branches would not serve.

B. Instructed the ISMS delegation to the American Medical Association to request AMA to seek legislation which would require the Food and Drug Administration to conduct public hearings throughout the country to avail itself of the large amount of accessible information possessed by practicing physicians regarding pharmaceutical preparations before the FDA arrives at decisions affecting the availability of pharmaceutical agents currently in use for the treatment of human illness.

C. Instructed the Board of Trustees to request the AMA Law Department, with physician assistance, to consider the question of the rights of the fetus and the pregnant woman in light of the due process and equal protection clauses of the United State Constitution.

D. Endorsed the concept and principle of the Pilot Project of Voluntary Arbitration of Professional and Institutional Medical Malpractice Claims as developed by the ISMS Medical-Legal Council and hospital association representatives. The project includes the prompt, equitable, just and private settlement of a claimed injury.

E. Indicated continued support for present anti-substitution laws.

F. Ordered the investigation and development of alternatives to protect patient rights as they relate to the contingency fee in suits for medical maloccurrance.

G. Rejected a request to have AMA seek legislation to simplify physician's federal narcotic numbers.

H. Agreed to resist attempts to require triplicate prescriptions for all state Schedule II, III and IV substances.

I. Approved development of amendments to any present legislation abridging the physician's prerogative to make medical judgments and agreed to oppose the Illinois Cancer Society's efforts to permit paramedical personnel to perform PAP smears.

J. Instructed the AMA delegation to request the American Medical Association to take appropriate steps to seek legislation which would insure that a minimum of 90 days be allowed for response to regulations published in the Federal Register. This provision would allow physicians and the public to have adequate time to respond to the far-reaching federal regulations.

K. Denounced federal bureaucracies for writing regulations that frequently circumvent the intent of the law and ordered publicity that will urge members and the public to write their legislators about this matter.

L. Referred to the Medical-Legal Council for further study a proposal that medicine help establish a peer review system for the legal profession.

Actions on Resolutions
1974 House of Delegates

Number	*Introduced By:*	*Subject*	*Action*
74A-1	William M. Lees	Continued Funding for ICCME	Adopted as amended
74A-2	William M. Lees	Smoking in Hospitals	Substitute resolution adopted
74A-3	Joseph R. O'Donnell	Amendment to Bylaws, Chapter I, Section 1H, In-Training Members	Adopted
74A-4	Joseph R. O'Donnell	Amendment to Bylaws, Chapter I, Section 1I, Student Members	Adopted
74A-5	Joseph R. O'Donnell	Amendment to Bylaws, Chapter II, Section 1, Dues	Adopted as amended
74A-6	Joseph R. O'Donnell	Amendment to Bylaws, Chapter II, Section 2, Reduction & Remission of Dues	Adopted
74A-7	Barry Seng	Chiropractic	Rejected
74A-8	A. J. Kiessel	Arbitrary Actions of FDA	Substitute resolution adopted
74A-9	Antonio Boba	Election of AMA Delegates & Alternates	Amended resolution rejected (no action on original)
74A-10	Julian W. Buser	Abortion Policy	Rejected
74A-11	H. Frank Holman	Amendment to U.S. Constitution	Substitute adopted as amended
74A-12	Warren D. Tuttle	Billing for Ancillary Personnel Services	Adopted
74A-13	H. Frank Holman	Rescinding Abortion Policy	Rejected
74A-14	Joseph Skom	Medical Psychotherapy	Substitute referred to Council on Mental Health & Addiction
74A-15	David T. Petty	Confidentiality	Adopted
74A-16	Guy Pandola	Alcoholism	Substitute adopted
74A-17	Joseph Skom	Limited License Physicians in State Hospitals	Rejected
74A-18	David T. Petty	Arbitration of Medical Personal Injury Claims	Adopted
74A-19	Joseph Skom	Diagnosis and Length-of-Stay Principles	Rejected
74A-20	William M. Lees	Repeal of Anti-Substitution Laws	Adopted
74A-21	David T. Petty	Contingency Fees in Professional Liability Suits	Adopted

Number	*Introduced By:*	*Subject*	*Action*
74A-22	Joseph Skom	Psychiatric Overnight Therapeutic Test Home Visits, Reimbursement by Medicare	Adopted
74A-23	Guy Pandola	Alcoholism Education	Adopted
74A-24	Guy Pandola	Misuse of Medical Prescriptions	Adopted (with editorial change)
74A-25	E. K. DuVivier	Approval of EPSDT Medichek Program	Substitute adopted
74A-26	William B. Frymark	Blue Shield Program	Rejected
74A-27	Alfred Klinger	Delayed Reimbursement by IDPA	Substitute adopted
74A-28	Gerald J. Liesen	Honorariums for Pres., Pres-Elect, & Chrmn. of the Board	Substitute adopted
74A-29	George J. Shimkus	Excessive Control of Physicians' Fees	Adopted
74A-30	Wayne N. Leimbach	Physician's Federal Narcotic Numbers	Rejected
74A-31	Allan L. Goslin	Deletion of Bylaws Section 6E of Chapter IX	Adopted
74A-32	A. Beaumont Johnson	Unified Voice of Organized Medicine	Deferred to an indefinite date
74A-33	Joseph Skom	Triplicate Prescription Forms	Adopted
74A-34	Forrest H. Riordan	Uterine Cytopathological Examination	Substitute adopted as amended
74A-35	Forrest H. Riordan	Limitation of Terms of Service	Referred to Committee on Constitution & Bylaws
74A-36	E. T. Leonard	Establishment of a 1-A Trustee District	Referred to the Board of Trustees
74A-37	Barry Seng	Uniform Health Insurance Claim Form	Adopted
74A-38	Guy Pandola	Health Screening by Paramedical Personnel	Adopted
74A-39	Jeff Waitzman	Membership Dues for Students	Adopted as amended
74A-40	Jeff Waitzman	Continued funding for Liaison with Students, Interns and Residents	Adopted
74A-41	Paul P. Lorenz	Medicaid Fee Schedule & Payment	Substitute adopted
74A-42	Joseph R. O'Donnell	Amendment to Chapter XII, Section 1 of Part 2	Adopted
74A-43	Joseph R. O'Donnell	Amendment to Chapter I, Membership	Adopted as amended
74A-44	William M. Lees	Relative Value Study	Adopted as amended

74A-45	Morgan M. Meyer	Intern/Resident Representation in House of Delegates	Adopted
74A-46	Morgan M. Meyer	Intern/Resident Dues	Adopted
74A-47	Forrest H. Riordan	Nomination for AMA Council on Medical Education	Withdrawn
74A-48	A. Beaumont Johnson	Legislative Intrusion into Medical Judgment	Rejected
74A-49	Morgan M. Meyer	Increasing Time for Responding to Regulations Published in Federal Register	Substitute adopted
74A-50	Morgan M. Meyer	Circumventing of Federal Laws by Federal Regulations	Adopted
74A-51	Wayne N. Leimbach	Peer Review & Public Relations	Referred to Medical Legal Council
74A-51A	William M. Lees	Legal Action on PSRO	Adopted
74A-52	William M. Lees	Medical Disciplinary System	Substitute adopted as amended
74A-53	Philip G. Thomsen	Health Maintenance Organizations	Adopted and referred to the Board of Trustees
74A-54	AMA Delegation	Relationships Between Local Medical Societies & Hospital Medical Staff	Adopted
74A-55	William M. Lees	Additional Dues Assessment	Adopted as amended
74A-56	AMA Delegation	AMA Public Affairs Committee	Adopted
74A-57	Eugene Johnson	IFMC as Agent and Negotiator for Fee Arrangements with 3rd Parties in Statewide Health Care Programs	Substitute adopted as amended
74A-58	Clark County Medical Society—George T. Mitchell	Investigation of IDPA and its Medical Fee Payment Procedures	Substitute adopted
Special	Fredric D. Lake	Creation of Select House Committee to Study ISMS Operations	Adopted without Reference

Convention Faces....



Doctor's News

ISMS and IHA ISSUE JOINT STATEMENT—The Executive Committees of the Illinois State Medical Society and the Illinois Hospital Association adopted a joint statement on April 4, 1974. The groups agreed that, "It is the responsibility of the hospital governing board to assure itself that a physician's license to practice medicine and his professional liability insurance are current and in force. This assurance should be provided by the medical staff." Hospital administrators are encouraged to share information about the institution's liability coverage with the medical staff. (The full statement is published on page 397.)

IDPH HELPING HEMOPHILIA VICTIMS—The Illinois Department of Public Health is launching a program to help cut the costs of care for hemophiliacs. Hemophilia has not previously been covered by any State funds, and obtaining insurance has been difficult; treatment of hemophilia has become very expensive with the new blood concentrates. IDPH is contacting all Illinois hospitals to determine which are willing and eligible to offer services as hemophilia centers. Those designated as centers will treat hemophilia at a lower cost to the patients. The State program will reimburse hospitals, pharmacies, blood banks and other health providers from a special State appropriation.

Doctors who see patients with hemophilia should have them contact: Hemophilia Program, Illinois Department of Public Health, 1130 South 6th Street, Springfield.

NEW AMA BOARD OFFICERS ELECTED—**Richard E. Palmer, M.D.,** was elected as Chairman of the AMA Board at their March meeting. The position became vacant upon the appointment of **James Sammons, M.D.,** Chairman of the Board since 1973, as the new Executive Vice President. **John M. Chenault, M.D.,** is the Vice Chairman of the Board.

INSTITUTE OF MEDICINE OFFERS TWO RESEARCH AWARDS—The annual Joseph A. Capps and Dr. and Mrs. Elven J. Berkheiser Prizes are being offered by the Institute of Medicine of Chicago. The awards are given for original research work completed in 1974 in the field of orthopaedic surgery and in medicine or in the specialties of medicine. For information, contact the Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago, 60604.

PHYSICIANS IN THE NEWS—**Harold E. Smith, M.D.,** was recently honored by the Women's Guild of the Westlake Community Hospital, Melrose Park, for his 50 years of service to the community.

James E. Bowman Jr., M.D., Director of Laboratories, University of Chicago Hospitals and Clinics, has been elected President of the Metropolitan Chicago Blood Council.

New Fellows of the American College of Anesthesiologists are **Usharani Nimmagadda, M.D.,** Glenview, and **Martin E. Zadigian, M.D.,** Waukegan.

George A. Wiltrakis, M.D., St. Charles, recently was elected President of the American Society of Abdominal Surgeons. Dr. Wilktrakis is the immediate Past President of Kane County Medical Society.

Officers of the Diabetes Association of Greater Chicago for 1974 are: **Joseph H. Skom, M.D.,** President; **Helen M. Wilks, M.D.,** First Vice President; and **Ann M. Lawrence, M.D.,** Secretary.

During the ISMS annual meeting, the Fifty Year Club held their annual luncheon. Sixty-six new members were inducted into this elite club upon completion of 50 years of service to the medical profession. New members of the ISMS Fifty Year Club are: Drs.

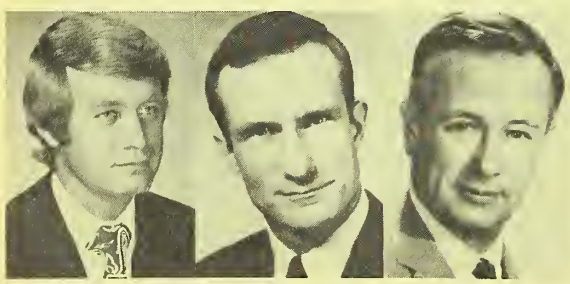
Joseph E. Allegretti
Henry Rex Amberson
Louis Croft Arp, Sr.
Knowlton Emmons Barber
George Alvin Barnett
Marshall R. Bascomb
Herbert F. Biswanger
Bruno Blumklotz
Wayne G. Brandstadt
Henry Harold Conley
Nathan N. Crohn
Bernard E. Ellis
David Epstein
Louis Feldman
Liborio Figueroa
George G. Fischer
Alexander J. G. Friend
Richard Jacob Gordon
Jacob S. Grove
Ernest Wallor Gutzmer
Chester Chappell Guy
Marshall Wesley Hall
Floyd L. Heinemeyer
Samuel Heller
Bernard Benjamin Heymann
Waldo Jerome Houghton
Charles Brenton Huggins
Frank Larkin Hessey, Sr.
Stanley John Imbiorski
Paul Immerwahr
Stanley F. Janicki
Louise Osborn Kappes
Joseph Landberg
Harry Leichenger
Harold Walter Lenit
Norbert Lewinson
David Joseph Lewis
Maude L. Lindsey
Wallace D. MacKenzie
Floyd L. McGrath
Samuel J. Meyer
Morton Joseph Mills
Eugene Franklin Moore
Edward Stephen Moser
Ernest Clarence Olson
Alfred Beam Owen
Herbert Pollack
Mary Howe Pope
Harold Addison Quint
Samuel W. Ramsey
H. Gordon Reid
Rudla Rind
Albert S. Rosenborough
William Schecter
Harold Edward Smith
Joseph Clarence Sodaro
Oscar Stein
Edgar M. Stevenson
Richard B. Stoops
Gustave Francis Tufo
Henry John Ulrich
Arthur S. Wagner
Gustave F. Weinfeld
Norman Turner Welford
Scott J. Wilkinson
Paul Philip Youngberg

Illinois Hospital Association Names New Head



Robert W. O'Leary, J.D., Executive Vice President of the Massachusetts Hospital Association, has been named to the chief executive post of the Illinois Hospital Association. Mr. O'Leary will assume duties as Executive Vice President of IHA on June 1. He succeeds David M. Kinzer, who will become President of the Massachusetts Hospital Association.

A Massachusetts native, Mr. O'Leary received his Juris Doctor Degree in 1973 from Suffolk University School of Law in Boston. He holds a Master's Degree in public administration and a Bachelor of Science degree in public health. He is a member of the American Society of Association Executives and in 1970 he was selected as one of the "Outstanding Young Men in America."



Dr. Tardy *Dr. Kerth* *Dr. Sisson*

Illinois Head and Neck Plastic Surgeons Elected to National Office

At the 10th annual scientific meeting of The American Academy of Facial Plastic and Reconstructive Surgery, Inc., Drs. M. Eugene Tardy, Jr., Oak Park; Jack Kerth, Chicago; and George A. Sisson, Chicago, were elected to serve as Secretary, Treasurer and Regional Vice President respectively.

Dr. Tardy is currently Associate Professor of Otolaryngology at the University of Illinois and serves as consultant to numerous Chicago area hospitals. He is the author of more than 50 scientific articles.

Dr. Kerth is Associate Professor in Otolaryngology and Maxillofacial Surgery at Northwestern University, McGaw Medical School. His academic and administrative responsibilities include: Associate Editor, AMA *Archives of Otolaryngology;* Instructor, Publications Committee and Education Committee of American Academy of Facial Plastic and Reconstructive Surgery. In 1973, Dr. Kerth was the recipient of the Award of Merit from the American Academy of Ophthalmology and Otolaryngology.

Dr. Sisson is Professor and Chairman of the Department of Otolaryngology and Maxillofacial Surgery at Northwestern University, McGaw Medical School. His chief area of research interest is cancer of the head and neck, for which he has produced several films illustrating operative techniques for control of cancer. Dr. Sisson is Chairman of the Head and Neck Rehabilitation of the American Cancer Society, Illinois Division and Chairman of the Committee on Surgery of the Head and Neck of the American Academy of Ophthalmology and Otolaryngology.

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*.134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

© 1973 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. 734017

Mead Johnson LABORATORIES

New Pharmaceutical Specialties

(Continued from page 412)

Dosage: Administered i.v., depending upon amount of blood lost.
Supplied: Bottles 500 cc., solution in 0.9% sodium chloride.

WAMPOCAP — Cholesterol Reducing Agent — o.t.c.
Manufacturer: Wampole Laboratories
Nonproprietary Name: Niacin
Indications: Adjunctive therapy in addition to diet in hypercholesterolemia and hyperbetalipoproteinemia
Contraindications: Hepatic dysfunction or active peptic ulcer
Precautions: See package insert
Dosage: 1 or 2 capsules t.i.d., adjust to response
Supplied: Capsules, 500 mg.

COMBINATION PRODUCTS

COMFOLAX-plus — Laxative — o.t.c.
Manufacturer: Searle Laboratories
Composition: Dioctyl Sodium Sulfosuccinate 100 mg.; Casanthranol 30 mg.
Indications: Constipation
Supplied: Capsules

DRI-HIST No. 2 — Nasal Decongestant — Rx
Manufacturer: Sutliff & Case Co. Inc.
Composition: Pyrilamine maleate 25 mg.; Phenylpropanolamine HCl 25 mg.; Pheniramine maleate 10 mg.; Phenylephrine HCl 10 mg.
Indications: Symptomatic relief of rhinitis, sinusitis, nasal allergies, hay fever and post-nasal drip.
Caution: Described in package insert
Dosage: Adults and children over 12 yrs; 1 capsules, repeat in 6 to 8 hours.
Supplied: Slow release capsules.

PROPOXYCHEL COMPOUND — Analgesic — Rx
Manufacturer: Rachelle Laboratories, Inc.
Composition: Propoxyphene HCl 65 mg.; Aspirin 227 mg.; Phenacetin 162 mg.; Caffeine 32.4 mg.
Indications: Relief of mild to moderate pain
Contraindications: Do not use in children; use with circumspection in pregnancy.
Precautions: Tolerance has been reported in some patients.
Dosage: One capsule three to four times daily.
Supplied: Capsules

NEW DOSAGE FORMS

ARISTOCORT A w. Aquatain — Local Corticosteroid — Rx
Manufacturer: Lederle Laboratories
Nonproprietary Name: Triamcinolone Acetonide
Indications: Symptomatic relief and management of the manifestations of corticosteroid-responsive skin conditions.
Precautions and Contraindications: Those applying to corticosteroid topical therapy
Dosage: Apply locally as required.
Supplied: In Aquatain hydrophylic base Tubes 15 and 75 gram, 0.1% Tubes 15 gram, 0.5%

TAPAR Elixir — Analgesic — o.t.c.
Manufacturer: Parke-Davis
Nonproprietary Name: Acetaminophen
Indications: Relief of mild pain
Dosage: See package insert
Supplied: Elixir, 120 mg/5 cc; 300 mg/12.5

Obituaries

**Falls, Frederick, River Forest, died February 8, at the age of 89. Dr. Falls had been a physician for more than 50 years. He was Chairman Emeritus of the ISMS Maternal Welfare Committee.

*Mozny, Vilem J., Chicago, died February 15, at the age of 60. He was a 1947 graduate of the University of Proba, Czechoslovakia.

*Reeves, Bryce B., Macomb, died March 1, at the age of 79. He had held many positions such as Flossmoor Commissioner of Health from 1939 to 1960 and also president of the school board there. He was the author of numerous articles pertaining to industrial medicine, heart disease, and alcoholism. Dr. Reeves had been a pioneer in the invention and development of skin grafting for burn treatment.

*Saletta, Salvatore N., died February 10, at the age of 65. He was a 1934 graduate of the Loyola University, Stritch School of Medicine.

*Sokolofski, Mary, Canada, died February 24, at the age of 79. She was a 1933 graduate of the University of Manitoba, Winnepeg.

*Tilkin, Leonard, Skokie, died March 13, at the age of 53. He had been a practicing psychiatrist and a graduate of the Chicago Medical School in 1945.

*Ziman, Charles, Chicago, died March 20, at the age of 68. He was on the staff of Illinois Masonic Hospital, and was a graduate of the Chicago Medical School in 1937.

**Denotes member of ISMS*
***Denotes member of 50-Year Club of ISMS*

IN SYPHILIS
INJECTION
Bicillin® LONG-ACTING
(STERILE BENZATHINE PENICILLIN G SUSPENSION) WYETH

Syphilis is preferably treated with benzathine penicillin G, which is also the drug of choice for prophylaxis after exposure. Administration of 2.4 million units (1.2 million in each buttock) usually cures most cases of primary, secondary and latent syphilis with negative spinal fluid.

Indications: In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

FOR DEEP INTRAMUSCULAR INJECTION ONLY.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms including fungi. Take appropriate measures should superinfection occur.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

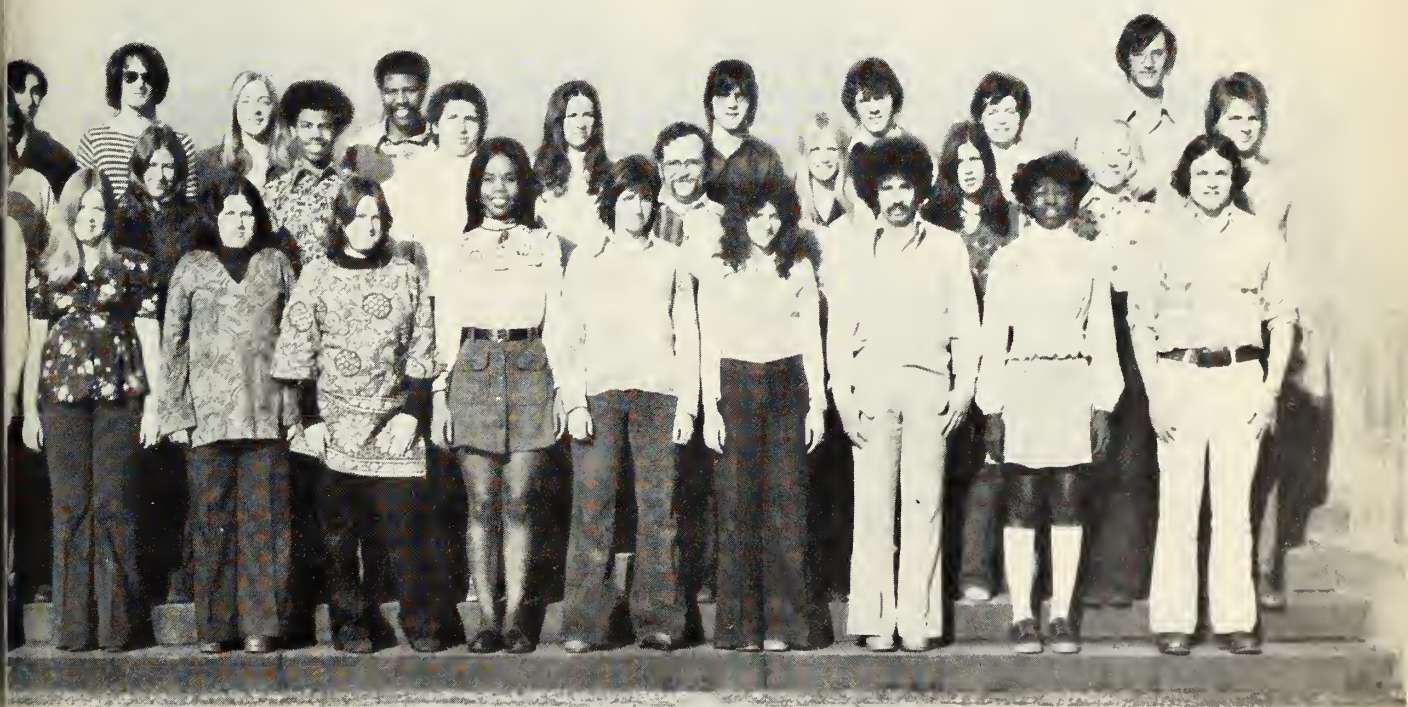
Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

Congenital—under 2 years of age, 50,000 units/Kg. body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

(Shake multiple-dose vial vigorously before withdrawing the desired dose.) Administer by **deep intramuscular injection** in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

Composition: 2,400,000 units in 4-cc. single dose disposable syringe. Each TUBEX disposable syringe also contains in aqueous suspension with sodium citrate buffer, as w/v approximately 0.5% lecithin, 0.4% carboxymethylcellulose, 0.4% polyvinylpyrrolidone, 0.01% propylparaben and 0.09% methylparaben. Units benzathine penicillin G (as active ingredient); 300,000 units per cc.—10-cc. multi-dose vial. Each cc. also contains sodium citrate buffer, approximately 6 mg. lecithin, 3 mg. polyvinylpyrrolidone, 1 mg. carboxymethylcellulose, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 0.14 mg. propylparaben and 1.2 mg. methylparaben.

Wyeth Laboratories
Philadelphia, Pa. 19101



*U.S. Dept. of Health, Education, and Welfare: VD Fact Sheet 1972. Publication No. (HSM) 73-8195.

Cecal Volvulus

(Continued from page 411)

pointed out here, usually there is a large distended segment of colon which extends, as a rule, from the right lower quadrant toward the left upper quadrant.

Another characteristic of X-ray findings is that distended loops of small bowel will seem to lie to the right of this distended loop of colon. If small bowel is seen to the right of an enlarged loop of colon, cecal, rather than sigmoid, volvulus is more likely. Barium enema is indicated to differentiate cecal from sigmoid volvulus and sigmoidoscopy can be performed for the same reason.

Conservative treatment is not indicated in cecal volvulus. It appears well established now that right colon resection with an ileotransverse colostomy is the treatment of choice. If the patient is critically ill, one can exteriorize this segment of bowel and later perform a definitive operation. In the past, many attempts at detortion of the volvulus were made with suture of the cecum to the lateral peritoneal wall in some manner. This has been found to be associated with a high rate of recurrence and with a mortality of approximately 50%; with right hemicolectomy, the mortality is approximately 10%.

Dr. Robert Geurkink: Dr. Williams has covered this topic well. In the patient today, there was some confusion about whether sigmoid or cecal volvulus was present. The value of barium enema examination was demonstrated in differentiating between the two. She did have some localized tenderness, probably due to her necrotic bowel, but this did not contraindicate the barium enema. The patient recovered uneventfully. ◄

Xanthogranulomatous Pyelonephritis

(Continued from page 407)

Red O (Fig. 8). An acute inflammatory process with micro-abscess formation is usually present. Occasionally, cholesterol clefts and foreign body giant cells are identified.

Experimentally, XGP has been induced in rats by ligation of the ureter and intravenous injection of *E. coli* 04:H5.[8] We have been able to produce XGP in mice by inducing diabetes and then ligating the ureter and injecting *Proteus* or *E. coli* into the obstructed kidney.

Nephrectomy is the only treatment of XGP. A high index of suspicion preoperatively facilitates determination of the proper surgical approach, avoidance of unnecessary and ineffective radiotherapy and chemotherapy, and establishment of an accurate prognosis.

Summary

Preoperative diagnoisis of XGP is important, because, clinically, it may be confused with renal cell carcinoma and tuberculosis. An accurate diagnosis is also desirable for the selection of the proper therapy and prognosis. Retrograde pyelogram (pseudo-extravasation), renal arteriogram, and Oil Red O staining have been most helpful in differentiation of this benign renal lesion from renal cell carcinoma. We believe this entity is more common than the literature indicates. The diagnosis depends on the awareness of the urologist and the ability of the pathologist to differentiate this entity from renal cell carcinoma and renal tuberculosis. ◄

References

A complete bibliography for "Xanthogranulomatous Pyelonephritis" can be obtained by writing: *Illinois Medical Journal*, 360 N. Michigan Ave., Chicago, IL. 60601.

75 YEARS

Professional Protection

CONTINUOUSLY

Since 1899

THE MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

CHICAGO AREA OFFICE:
T. J. Pandak, J. C. Kunches, L. R. Gannan, and W. G. Prangle, Representatives
815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314
SPRINGFIELD OFFICE: W. J. Nattermann, Representative
426½ South Fifth Street, Springfield 62701 (217) 544-2251

ISMS Scientific Speakers Bureau

County societies are invited to take advantage of the ISMS Scientific Speakers Bureau, which provides services ranging from planning an entire program to paying the honorarium for a speaker selected by the county society. The Bureau also maintains a list of available speakers. To use any of these services, arrangements must be made well in advance. The Bureau operates under a grant from Merck, Sharp, & Dohme.

For full information, write to . . .
Scientific Speakers Bureau
Illinois State Medical Society
360 North Michigan Avenue
Chicago, IL 60601

Pediatrics

INTENSIVE COURSE IN PEDIATRIC NUTRITION
For: All physicians. June 3-5, 1974, University of Iowa College of Med., Iowa City. **Hrs. of Instr.:** 24. **CME Credit:** AMA Category 1. **Fee:** $15. **Reg. Limit:** 50. **Sponsor, contact:** Univ. of Iowa College of Med., Newton Rd., Iowa City, IA 52242.

NEUROMUSCULAR & LEARNING DISORDERS IN CHILDREN
For: All physicians. June 10-14, 1974, Chicago. **Hrs. of Instr.:** 27. **CME Credit:** AMA Category 1. **Fee:** $175. **Reg. Limit:** 30. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

SPECIALTY REVIEW COURSE IN PEDIATRICS
For: Pediatricians. June 17-22, 1974, Chicago. **Hrs. of Instr.:** 38. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 85. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

Psychiatry

POSTGRAD COURSE IN PSYCHIATRY FOR GENERAL PRACTITIONERS & SPECIALISTS
For: Family Physicians, Psychiatrists. June 1-3, 1974, University of Iowa College of Med., Iowa City. **Hrs. of Instr.:** 17. **CME Credit:** AMA Category 1. **Sponsor, contact:** Univ. of Iowa College of Med., Newton Rd., Iowa City, IA 52242.

Surgery

PLASTIC SURGERY OF THE AGING FACE
For: Plastic Surgeons, Otolaryngologists. 5-day symposium, June 1-5, 1974, Univ. of Illinois Eye & Ear Infirmary, Chicago. **Hrs. of Instr.:** 45. **Fee:** $450. **Sponsor, contact:** M. Eugene Tardy, Jr., M.D., Chm. Dept. of Otolaryngology, Univ. of Ill. College of Med., Eye & Ear Infirmary, 1855 W. Taylor St., Chicago, IL 60612.

MANAGEMENT OF TUMORS OF HEAD & NECK
For: Surgeons. June 10-14, 1974, Chicago. **Hrs. of Instr.:** 35. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 55. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

4th ANNUAL POST-GRAD COURSE IN SURGERY: MANAGEMENT OF COMMON SURGICAL PROBLEMS
For: General Surgeons. June 20-21, 1974, Passavant Pavilion, Northwestern Mem. Hosp., Chicago. **Hrs. of Instr.:** 16. **CME Credit:** AMA Category 1. **Fee:** $100. **Reg. Limit:** 100. **Sponsor:** Northwestern Univ. Dept. of Surgery; Amer. College of Surgeons. **Contact:** Jacob Suker, M.D., Dept. of Post-Grad. Educ., Northwestern Univ. Med. Sch., 303 E. Chicago Ave., Chicago, IL 60611.

INFECTIONS IN SURGERY
For: Surgeons. Annual Surgical Forum, June 23, 1974, Pick Congress Hotel, Chicago. **Hrs. of Instr.:** 8. **CME Credit:** AMA Category 1. **Fee:** $25. **Reg. Limit:** 400. **Sponsor, contact:** Amer. Soc. of Abdominal Surg., 675 Main St., Melrose, Mass. 02176.

JULY

Family Medicine

FAMILY PRACTICE REVIEW
For: Family Physicians. Symposium, July 9-11, 1974, Stouffer's Indianapolis Inn, Indianapolis. **Hrs. of Instr.:** 26½. **CME Credit:** AAFP, AMA Category 1. **Fee:** $75. **Sponsor, contact:** Mr. John Roscoe, Program Coord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

General Interest

PAS & MAP TUTORIAL SESSION
For: Physicians, Hosp. Admin., Allied Health. July 10-11, 1974, Ann Arbor, Mich. **Hrs. of Instr.:** 12. **CME Credit:** AMA Category 1. **Fee:** $110 (1-4 persons, if at least 2 physicians). **Sponsor, contact:** Commission on Professional & Hosp. Activities, 1968 Green Rd., Ann Arbor, MI 48105.

SUMMER PROGRAM ON HUMAN SEXUALITY
For: All physicians. 11-day workshop, July 14-25, 1974, Bloomington, Ind. **Hrs. of Instr.:** 90. **CME Credit:** AMA Category 1. **Fee:** $250 + housing & meals. **Reg. Limit:** 125. **Sponsor, contact:** Institute for Sex Research, Indiana Univ., 416 Morrison Hall, Bloomington, IN 47401.

Obstetrics/Gynecology

GYNECOLOGICAL LAPAROSCOPY
For: Board certified or eligible specialists. 5-day course, July 15-19, 1974, Chicago. **Hrs. of Instr.:** 15. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 8. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

VAGINAL APPROACH TO PELVIC SURGERY
For: Board certified or eligible specialists. 6-day course, July 15-20, 1974, Chicago. **Hrs. of Instr.:** 20. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 16. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Surgery

FIBEROPTIC COLONOSCOPY
For: All physicians. 3-day course, July 10-12, 1974, Chicago. **Hrs. of Instr.:** 21. **CME Credit:** AMA Category 1. **Fee:** $125. **Reg. Limit:** 10. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

UPPER MIDWEST REVIEW OF GASTROENTEROLOGY
For: Family Physicians, General Surgeons, Proctologists, Gastroenterologists. 1½-day seminar, July 13-14, 1974, Pfister Hotel, Milwaukee, Wis. **Hrs. of Instr.:** 10. **CME Credit:** AAFP. **Fee:** $125. **Reg. Limit:** 125. **Sponsor, contact:** A. T. Finnegan, Ofc. of Cont. Educ., The Medical College of Wisconsin, 561 N. 15th St., Milwaukee, WI 53233.

ADVANCED PERIPHERAL VASCULAR SURGERY
For: Specialists. 5-day course, July 15-19. 1974, Chicago. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 40. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY
For: Specialists. 3-day course, July 31-Aug. 2, 1974, Chicago. **Hrs. of Instr.:** 19½. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 10. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Multi-Media Learning Materials—MEDCOM

One of the most complete collections of multi-media study materials for physicians, MEDCOM includes slides, video tapes, programmed instruction, illustrated study-guides, *etc.*, covering a wide variety of medical topics.

For full information, write to . . .
MEDCOM, Inc.
2 Hammarskjold Plaza
New York, N.Y. 10017

Your Personal Learning Plan

Are you satisfied that your CME is producing full benefits for the time (and money) invested? If you've any doubts, try *Your Personal Learning Plan*, a 32-page pamphlet intended to help the individual physician plan CME in a systematic fashion.

While written chiefly for primary-care practitioners—family physicians, internists, pediatricians—the pamphlet can also be useful to those specialists who ordinarily deal with a smaller range of medical problems.

A unique feature of this handbook is a special set of worksheets—similiar in format to the patient medical record to help you think through and record YOUR personal learning plan.

Any Illinois physician (MD or DO) may have a copy FREE upon request; simply write "Personal Learning Plan" on your prescription form, and mail to ICCME (*address above*). To all others, the cost is $1.00/copy postpaid (90c each in quantities of 100 or more).

AUGUST

Emergency Care

EMERGENCY MEDICAL CARE
For: All physicians. August 12-16, 1974; Wisconsin Cntr., Madison, Wis. **Sponsor, contact:** Univ. of Wisconsin, Dept. of Continuing Med. Educ., 610 N. Walnut St., Madison, WI 53706.

Family Medicine

SPECIALTY REVIEW COURSE FOR FAMILY MEDICINE
For: Family Physicians. 10½-day course, August 12-23, 1974, Chicago. **Hrs. of Instr.:** 98. **CME Credit:** AMA Category 1. **Fee:** $300. **Reg. Limit:** 150. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

General Interest

PAS & MAP TUTORIAL SESSION
For: Physicians, Hosp. Admin., Allied Health. August 7-8, 1974, Ann Arbor, Mich. **Hrs. of Instr.:** 12. **CME Credit:** AMA Category 1. **Fee:** $110 (1-4 persons, if at least 2 physicians). **Reg. Limit:** 75. **Sponsor, contact:** Commission on Professional & Hosp. Activities, 1968 Green Rd., Ann Arbor, MI 48105.

Orthopedics

SPECIALTY REVIEW COURSE IN ORTHOPAEDICS
For: Specialists. 6½-day course, August 25-31, 1974, Chicago. **Hrs. of Instr.:** 60. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 60. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Psychiatry

WINNEBAGO SYMPOSIUM FOR GENERAL PRACTITIONERS
For: Family Physicians. August 22, 1974, The Pioneer Inn, Oshkosh, Wis. **Hrs. of Instr.:** 6. **CME Credit:** AMA Category 1. **Fee:** $15. **Reg. Limit:** 60. **Sponsor, contact:** Winnebago State Hospital, Box H, Winnebago, WI 54985.

View Box

(Continued from page 414)

DIAGNOSIS: *Urachal Sinus*—The patient was examined by injecting contrast media through a catheter placed in a sinus in the umbilicus which revealed an opacified ovoid mass. The urinary bladder did not fill with contrast media which indicated that the communication from the umbilicus was incomplete. The narrowed apex of the bladder continuous with the allantoic stalk at the umbilicus is called the urachus. In an early developmental stage this structure undergoes regression normally resulting in complete obliteration. Failure to obliterate results in patent urachus or urachal cysts.

A classification of abnormalities is as follows:

(1) Complete communication at both ends resulting in a patent urachus.

(2) Communication of the urinary bladder with the urachal remnant but non-filling to the umbilicus results in a urachal diverticulum.

(3) Communication of the umbilicus to a duct-like structure which does not communicate with the bladder is a urachal sinus.

(4) Residual cysts in the urachal remnant are properly called urachal cysts, and may not communicate with the umbilicus or the bladder.

(5) The last category reflects the rare anomaly of an undecended bladder which opens directly into the umbilicus and represents a widely opened omphalovesical fistula. ◄

COOK COUNTY
Graduate School of Medicine
CONTINUING EDUCATION COURSES
STARTING DATES, 1974

SPECIALTY REVIEW IN MEDICINE, CERTIFYING, June 10
SPECIALTY REVIEW FOR FAMILY PRACTCE, August 12
SPECIALTY REVIEW IN ORTHOPAEDICS, August 25
SPECIALTY REVIEW COURSES IN PULMONARY & RHEUMATOLOGY, September 9
SPECIALTY REVIEW COURSES IN HEMATOLOGY, INFECTIOUS DISEASES & NEPHROLOGY, Sept. 30
SPECIALTY REVIEW IN SURGERY, PART I, Sept. 30
MANAGEMENT OF TUMORS OF HEAD & NECK, One Week, June 10
ADVANCED PERIPHERAL VASCULAR SURGERY, One Week, July 15
MANAGEMENT OF COMPLICATIONS IN SURGERY, 4 Days, Sept. 16
MANAGEMENT OF COMMON FRACTURES, One Week, Oct. 28
FLUIDS & ELECTROLYTES, One Week, Sept. 23
BASIC GYNECOLOGY, One Week, September 16
COURSE IN GYNECOLOGY PATHOLOGY, One Week, Oct. Vember
SPECIAL COURSE IN GYNECOLOGIC PATHOLOGY, One Week, Oct. 14
BASIC ELECTROCARDIOGRAPHY, One Week, Oct. 28
NEUROMUSCULAR DISEASES OF CHILDREN, One Week, June 10
NEUROLOGY, PART II, CLINICAL, One Week, September 9
PSYCHIATRY FOR THE MEDICAL PRACTITIONER, 4 Days, Oct. 7
STATE & NATIONAL BOARD REVIEW, Basic & Clinical, Oct. 14 & 20

Information concerning numerous other continuation courses available upon request.

Address:
REGISTRAR, 707 South Wood Street,
Chicago, Illinois 60612

Housestaff News

(Continued from page 418)

In addition, the unfortunate graduate, foreign or domestic, who fails the *Qualifying A* examination would become a probationary house officed, relegated to the poorer teaching programs least equipped to prepare him for *Qualifying B*.

Moonlighting, presently indulged in by a majority of housestaff, would become illegal, since an independent license to practice would be denied until completion of specialty boards. This outside income, needed to lessen the financial burden on housestaff who have accumulated debts during medical school would be denied. More importantly, the many people whose only access to medical care is through housestaff moonlighting activities would be denied this care.

An excellent discussion of the implications and probable complications of this report can be found in the January, 1974, issue of *Hospital Practice* and a summary can be found in the July 23, 1973 issue of *JAMA*. The Physicians National Housestaff Association (PNHA), the AMA Interns and Residents Business Session and the AMA Committee on House Staff Affairs have all voiced strong opposition to the GAP committee report, in particular, the section dealing with licensure.

All housestaff members are urged to discuss this subject at their local hospital organization or county medical society. ◄

Reference

1. "Evaluation in the Continuum of Medical Education—Report of the Committee on Goals and Priorities of the National Board of Medical Examiners." 3930 Chestnut Street, Philadelphia, National Board of Medical Examiners, June, 1973.

EKG of the Month

(Continued from page 413)

Answers: *1. B,C 2. D*

The 3 lead rhythm strip shows atrial fibrillation with an irregular but slow ventricular response. The R-R cycles, counting from the left, numbered, 2, 6, and 7 are all long although unequal. They would be in keeping with a rate below 50 beats per minute and suggest junctional escape beats except the R-R cycles are not equal. This might be explained by concealed conduction of atrial fibrillation. This means the patient has enough digitalis and a maintenance dose should be continued. More digitalis might result in a junctional rhythm and digitalis toxicity. ◄

Abstracts of Board Actions

(Continued from page 397)

mental Affairs Council for study and report back to the Board. The Mental Health Council recommended that ISMS support programs of the Illinois Department of Mental Health which are sound, patient oriented, and geared to improvement of the quality and delivery of services to the mentally ill, based on review of the merit of each proposal or program. The council also recommended that ISMS oppose HB 2223, because it impinges upon the ability of the Department to manage efficiently the affairs of the Department and effectively blocks physician management of the care of patients.

Objections to Magazine Articles

The Board accepted a recommendation of the Council on Mental Health and Addiction that complaints about recent articles in Today's Health and the Archives of General Psychiatry be forwarded to the American Medical Association.

AMA Standard Insurance Claim Form

On recommendation of the Council on Economics and Peer Review, the Board approved the AMA standard insurance claim form for use by Illinois physicians It will replace the present HIC form being provided by ISMS as a service to members.

Peer Review Guidelines

The Board approved the peer review guidelines developed by the Council on Economics and Peer Review in cooperation with health insurance carriers. However, its approval is contingent upon evidence that: (1) the carrier's medical department reviewed the physician's disputed billing, and, (2) the physician is informed where to contact the carrier's medical director should he wish to discuss the medical aspects of the case.

National Physician's Union

A request from the National Physician's Union for support of legal action to prevent implementation of federal regulations requiring preadmission certification for hospital admissions was refused by the Board, which noted that the AMA can more appropriately deal with these problems on a national level.

Model Health Insurance Plan

The Board accepted a progress report on the development of a model health insurance plan which indicated that the matter had been referred to the Uniform Administrative Procedures and Reimbursement Policies Committee of the Illinois Foundation for Medical Care.

Reconsideration of Medichek Endorsement

As a result of MEDICHEK's fixed fee schedule for physician services, the Board withdrew its endorsement of the program pending discussions with the Illinois Department of Public Health. The Department will be urged to discard the program's fee schedule in favor of the usual, customary and reasonable manner of reimbursement.

Insurance

The Insurance Committee was instructed to request the administrator of the Society's professional liability program to notify ISMS whenever cancellation of coverages is planned for any member, so that individual follow up can be made. The Board expressed concern that a member's policy might lapse because premiums were missed inadvertantly.

Joint Management Committee

The Board accepted the Joint Management Committee recommendations that technical and scientific exhibits should be discontinued at the combined Midwest Clinical Conference and 1975 annual meeting of ISMS. The committee also recommended that CMS be responsible for postgraduate and instruction courses, ISMS for the House of Delegates and related meetings and that ISMS underwrite the scientific program deficit up to $15,000. The Board deferred action on the agreement to provide this funding.

Champaign TB Sanitorium

In response to a request from Dr. Anthony F. Karich, Medical Director of the Champaign County Tuberculosis Sanatorium, the Board agreed to offer its assistance to the Champaign County Medical Society in resolving problems arising from a recent adverse report on the sanitorium by the Illinois Department of Public Health Tuberculosis Control Office.

Ethical Relations

Upon recommendation of its Ethical Relations Committee, the Board upheld the censureship of an Illinois physician on two counts of unethical conduct.

Elect Dr. Bordenave Chairman

First District Trustee Dr. Joseph L. Bordenave, Geneva, was elected chairman of the Board of Trustees for 1974-75. He succeeds Third District Trustee Dr. William Lees, Lincolnwood.

LOW-COST GROUP INSURANCE
ANOTHER ISMS MEMBERSHIP PRIVILEGE

THE GROUP DISABILITY PLAN ● Provides up to $300.00 weekly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

BUSINESS OVERHEAD EXPENSE PLAN ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

THE FAMILY MAJOR MEDICAL EXPENSE PLAN ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Gross Daily Hospital Room and Board available. ● Subject to choice of deductible and 80% coinsurance.

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:
PARKER, ALLESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

Central Illinois Service Office: 849 Forest Lane—Petersburg, Ill. 62675 • phone 217-632-7220
Wayne J. Hubbert, District Manager

BLUE SHIELD REPORT FOR *Illinois Physicians*

Motors Groups Double Reciprocity Membership

As of June 1st, 2,500,000 employees and dependents of the Chrysler Corporation, Ford Motor Company and General Motors were enrolled in Blue Shield's Reciprocity program. Developed by the National Association of Blue Shield Plans, Reciprocity is a system of local Blue Shield payment of claims for services to patients who are members of *other* Blue Shield Plans.

The program began in 1972 and covers over 5 million members. By the end of this year it is estimated that other national accounts will be enrolled, raising the total covered to 10 million persons. At the national level, NABSP is sponsoring a series of messages in medical publications emphasizing the program's simplicity and guarantee of payment to physicians.

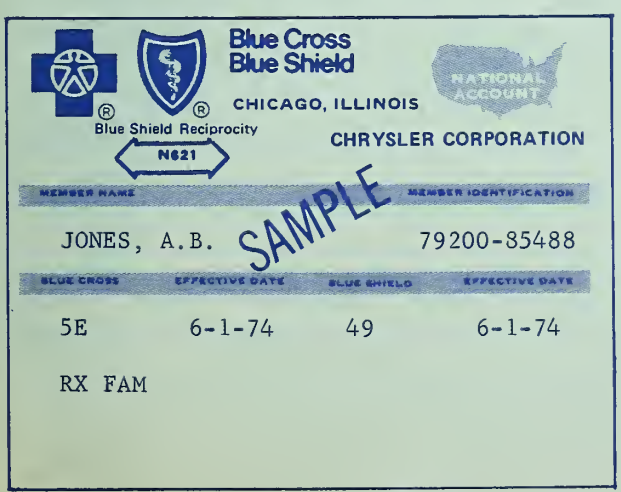
Reciprocity offers you these advantages:

(1) No contact with another Blue Shield Plan is necessary, nor use of an unfamiliar Blue Shield form.

(2) There is no delay while another Blue Shield Plan contacts Illinois Medical Service regarding charges in our area.

(3) Payment of covered services is guaranteed. When membership information is recorded properly on the Physician's Service Report, payment for covered services is made promptly.

(4) Payment is made on the Usual and Customary basis. A physician receives 100% of his usual fee when that fee is within the range of usual fees charged by physicians of similar training and experience for services covered under this special contract.



Red Arrow Symbol

All Reciprocity Blue Shield subscribers carry identification cards bearing a double-pointed red arrow in the upper left quadrant. A series of three numbers preceded by the letter "N" appear within this red arrow. This number indicates the "Home Plan" of the subscriber. Over 13,000 members of the Chrysler Corporation group in Illinois have now been issued Reciprocity identification cards. (A sample of the card is shown below.) Besides the red arrow and corporate identification this special card also carries an "RX" designation for pharmacy service coverage.

How the Program Works

After providing services to a Reciprocity-elegible patient from *another* Blue Shield Plan, you simply complete an Illinois Medical Service Physician's Service Report in the usual manner with ONE exception. Enter both the letter N and the three-digit number as it appears in the arrow PLUS the patient's group and certificate number on the group and subscriber number line on the Physician's Service Report. This enables our claims examiners to identify readily the claim as a Reciprocity system claim and to allow us to coordinate with the "Home Plan" after payment is made.

Scope of Benefits

Under the program the following services are covered on a Usual and Customary basis:

Surgery, wherever performed; anesthesia; radiation therapy; in-hospital medical care; in-hospital X-ray and laboratory services; in hospital or out-patient emergency medical care; emergency accident care; consultation while member is a bed patient in hospital; in-hospital care for tuberculosis, mental disorders, drug and alcohol addiction.

For medical care not listed above, such as maternity or out-patient diagnostic X-rays or laboratory services, the physician should bill the member's home plan as previously.

(This report is a service to the physicians of Illinois)

ASK BLUE SHIELD . . . ABOUT MEDICARE

Suppliers of Part B Services Must Have Medicare Program Certification

Inquiries made to the Blue Shield Plan of Illinois Medical Service from potential supplier sources including independent laboratories, portable X-ray services, independent physical therapists, certain physical therapy clinics, and ambulance services often concern the basic procedure for obtaining certification for Medicare participation.

With the exception of ambulance services, our replies to the above categories of suppliers emphasize they must be certified initially by the Illinois Department of Public Health and the Bureau of Health Insurance, Social Security Administration, to qualify for payment of services provided to Medicare beneficiaries.

Illinois Medical Service is the certifying agency for hospital-based ambulance services in Illinois and independent ambulance services in Cook County. Continental Casualty Company certifies independent ambulance services in counties other than Cook in the state.

The procedure of certification for (1) independent laboratories (2) portable X-ray services (3) independent physical therapists and (4) certain physical therapy clinics follows in this sequence:

— The initial request must be made to the Illinois Department of Public Health. The request should be addressed to Mr. Douglas Wade, Administrator, Federal Program, Division of Health Facilities, Department of Public Health, 1130 South Sixth Street, Springfield, Illinois 62761.

— The carbon copy of the request should be addressed to Mr. James R. Salla, Program Officer, Bureau of Health Insurance, Social Security Administration, Regional Office V, 300 South Wacker Drive, Chicago, Illinois 60606.

— The Illinois Department of Public Health initiates the review of the potential provider, either by an on-sight evaluation of the facilities or the completion of survey forms.

— The state health agency then notifies the Bureau of Health Insurance office of its findings. The Bureau of Health Insurance determines if the provider meets the conditions of participation for the services he intends to furnish to the Medicare program.

— The appropriate Medicare carrier, having regional jurisdiction, is then notified of the certification by the Bureau of Health Insurance.

— When the Part B Medicare carrier is notified of the certification a provider number is issued. At the present time, a change in location and/or ownership of an independent laboratory, physical therapy clinic or portable X-ray service requires new certification and a new provider number. A change in address of an independent physical therapist does not.

• *Independent Laboratory:* Its ownership is independent of both an attending physician or consulting physician's office, and of a hospital that meets at least the definition of an emergency hospital. One of the conditions for coverage of services of an independent clinical laboratory is that the laboratory agrees to perform only specific tests for Medicare beneficiaries. Services rendered for non-certified tests would not be paid. The laboratory undergoes periodic reviews by the Illinois Department of Public Health to maintain program certification.

• *Portable X-ray Services:* Diagnostic portable X-ray services may be provided in a patient's home or non-participating institution, but performed *under the general supervision of a physician.* Diagnostic portable X-ray services are covered under Part B when provided in participating Extended Care Facilities and hospitals under circumstances in which they *cannot be covered by Medicare hospital benefits.* Tests must be provided on the written order of a physician, and all bills involving X-rays of the chest should also contain the reason the X-ray was required. The scope of benefits include (1) skeletal films of arms and legs, pelvis, vertebral column and skull (2) chest films and abdominal films not requiring the use of a contrast media.

• *Independent Physical Therapist:* To be certified as an independent physical therapist, the therapist himself is responsible for the overhead expenses of his practice. He is not on an employee-employer arrangement. He is paid directly by the beneficiary for his services rather than by an organization or an employer. Services are provided to the Medicare beneficiary in the physical therapist's office, in the beneficiary's home or in another approved setting in which the physical therapist is the sole provider of services.

• *Certain Physical Therapy Clinics:* There are a number of clinics that are certified under both Medicare Part A and Part B to provide physical therapy services. As Part A providers they submit bills to an intermediary; as a Part B service, claims are sent to the Part B carrier. In some instances, physical therapists on the staff of a clinic or institution are also certified as being in independent practice. When any services are rendered by the physical therapist under the jurisdiction, and while an employee of a clinic or institution, the services must be billed by that facility to the Part A intermediary or Part B carrier as a clinic or institution service. If the independent physical therapist is providing services on an outpatient basis he may be paid directly by the beneficiary or bill Medicare Part B directly.

(This report is a service to the physicians of Illinois)

IMJ
Illinois Medical Journal

JUNE, 1974 CONTENTS Vol. 145, No. 6

539 Accumulative Index, Volume 145

Special Articles

484-491 History of the *Illinois Medical Journal;* Currents and Counter Currents in Medicine in 1899; Medical Journalism in Illinois; 75 Years Ago . . .; The Remarkable Dr. Hill; and Personal Dedications Guide Physicians

529 The Role of the Social Worker in a Community Hospital
Joseph F. Hinkamp, M.D.

Clinical Articles

493 Clinical Variations of Cystic Fibrosis
Daniel G. Cunningham, M.D.

497 Neuromuscular Dysfunctions of the External Urinary Sphincter
Nader Sadoughi, M.D., and Irving M. Bush, M.D.

500 Electrical Alternans
Case Report and Comments on its Mechanism and Diagnostic Significance
Sudarshan Kumar, M.D., and M. K. Dayhem, M.D., Ph.D.

Clinical Articles (Continued)

503 Treating Psoriasis of the Scalp With a New Corticosteroid Lotion
Roland S. Medansky, M.D., and Raymond M. Handler, M.D.

505 Lithium Carbonate in the Treatment of Manic-Depressive Disorders: A Follow Up Study
Patricia A. Mueller, M.D., and Edward A. Wolpert, M.D.

512 Speech Therapy For the Mildly Dysphasic Patient: When is it Indicated?
Judy Spector Huret, M.A., and Henry B. Betts, M.D.

515 Abdominal Wall Abscess in an Infant
Raymond J. Romanus, M.D.

517 Rediscovery of Cushing's Forceps
Hugh A. Johnson, M.D.

518 Rape
Robert Hartman, M.D.

526 Pediatric Perplexities: Epigastric Pain and Vomiting With or Without a History of Trauma
Hugh V. Firor, M.D.

Surgical Grand Rounds

520 Hyperparathyroidism and Pregnancy
John M. Beal, M.D., Editor

Turning Back the Pages

Since the diamond is symbolic of a 75th anniversary, it is appropriate that this month's cover depict this lusturous gem to commemorate the 75th year of publication of the *Illinois Medical Journal.*

This issue turns back the pages to review the steps leading to the first volume of the *IMJ* in 1889; to glance at organized medicine in 1899; to examine medical journalism in Illinois; to see what was taking place in 1890; and to reflect with a 100-year-old physician.

. . . We Look Forward

We turn back the pages with pride, and are proud of the progress in the past 75 years. We look forward to continued service to the Illinois physicians for many years to come.

Publications Committee

Jacob E. Reisch, M.D., *Chairman*
Eugene T. Hoban, M.D. James A. McDonald, M.D.
Frederick E. Weiss, M.D. Warren W. Young, M.D.

(Contents continued overleaf)

Features

472 Clinics For Crippled Children
477 President's Page
485 Editorial
524 Doctor's News
525 EKG of the Month
532 Pulse of the Doctor's Wife
534 ISMS Guide to Continuing Medical Education
536 Illinois Housestaff News
537 New Pharmaceutical Specialties
542 Physician Recruitment
544 Obituaries
545 Classified Advertising

(Cover by Mike White/Communications; diamond furnished by Henry Kay Jewelers, Chicago)

Staff

Editor **Theodore R. Van Dellen, M.D.**

Managing editor **Richard A. Ott**

Assistant editor **Joyce Gallagher**

Executive administrator **Roger N. White**

PUBLICATIONS COMMITTEE

Jacob E. Reisch, M.D., Springfield, *Chairman*
Eugene T. Hoban, M.D., Oak Park
Frederick E. Weiss, M.D., Harvey
James A. McDonald, M.D., Geneva
Warren W. Young, M.D., Crete

Contributor in Surgery: John M. Beal, M.D., Chicago
Contributor in Medical Progress: Harvey Kravitz, M.D., Skokie
Contributor in Maternal Death Studies:
Robert Hartman, M.D., Jacksonville
Contributor in Pediatric Perplexities: Ruth A. Seeler, M.D., Chicago
Contributor in Radiology: Leon Love, M.D., Maywood
Contributor in Cardiology: John R. Tobin, M.D., Maywood

ILLINOIS STATE MEDICAL SOCIETY

360 N. Michigan Ave., Chicago, 60601

OFFICERS

Fredric D. Lake, M.D., President
1041 Michigan Ave., Evanston 60202

J. M. Ingalls, M.D., President-Elect
502 Shaw, Paris 61944

Harold A. Sofield, M.D., 1st Vice-President
715 Lake Street, Oak Park 60301

Robert Hartman, M.D., 2nd Vice-President
1515A W. Walnut Street, Jacksonville 62650

Jacob E. Reisch, M.D., Secretary-Treasurer
1129 S. 2nd St., Springfield 62704

HOUSE OF DELEGATES

Andrew J. Brislen, M.D., Speaker of the House
6060 S. Drexel Blvd., Chicago 60637

James A. McDonald, M.D., Vice-Speaker
13 S. 2nd St., Geneva 60134

TRUSTEES

1st District: 1977, Joseph L. Bordenave, M.D.
1665 South Street, Geneva 60134

2nd District: 1977, Allan L. Goslin, M.D.
712 N. Bloomington, Streator 61364

3rd District: 1976, David S. Fox, M.D.
20829 Greenwood Center Ct., Olympia Fields 60461

3rd District: 1976, Robert T. Fox, M.D.
2136 Robin Crest, Glenview 60025

3rd District: 1975, Eugene T. Hoban, M.D.
6429 North Ave., Oak Park 60302

3rd District: 1975, Joseph Skom, M.D.
707 Fairbanks Ct., Chicago 60611

3rd District: 1977, William M. Lees, M.D.
6518 North Nokomis, Lincolnwood 60646

3rd District: 1977, George Shropshear, M.D.
1525 E. 53rd St., Chicago 60615

3rd District: 1977, Philip G. Thomsen, M.D.
13826 Lincoln Ave., Dolton 60419

3rd District: 1976, Frederick E. Weiss, M.D.
15643 Lincoln, Harvey 60426

3rd District: 1975, Warren Young, M.D.
3450 Haweswood Dr., Crete 60417

4th District: 1976, Fred Z. White, M.D.
723 N. 2nd St., Chillicothe 61523

5th District: 1976, A. Edward Livingston, M.D.
326 Fairway Dr., Bloomington 61701

6th District: 1975, Mather Pfeiffenberger, M.D.
State and Wall Sts., Alton 62002

7th District: 1976, Arthur F. Goodyear, M.D.
142 E. Prairie, Decatur 62523

8th District: 1976, Eugene P. Johnson, M.D.
P.O. Box 68, Casey 62420

9th District: 1975, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946

10th District: 1975, Herbert Dexheimer, M.D.
301 S. Illinois, Belleville 62220

11th District: 1977, Ross Hutchison, M.D.
126 E. Ninth St., Gibson City 60936

Trustee-At-Large: Willard C. Scrivner, M.D.
6600 West Main, Belleville 62223

Chairman of the Board: Joseph L. Bordenave, M.D.
1665 South Street, Geneva 60134

Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of *IMJ* are listed in the *Current Contents/ Clinical Practice.*

Published by the Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601 (312-782-1654)

Copyright, 1974. The Illinois State Medical Society.

Subscription $8.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands and Mexico. $10.00 per year for all foreign countries included in the Universal Postal Union. Canada $8.50. U.S. Single current copies available at $1.00 ($1.10 by mail), back issues $1.50.

Second class postage paid at Chicago, Ill. When moving please notify Journal office of new address including old mailing label with notification, if possible. POSTMASTER: Send notice on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago, Ill. 60601.

Pharmaceutical advertising must be approved by the ISMS Publications Committee. Other advertising accepted after review by Publications Committee or Board of Trustees. All copy or plates must reach the Journal office by the fifteenth of the month preceding publication. Rates furnished upon request.

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The ISMS denies responsibility for opinions and statements expressed by authors or in excerpts, other than editorial or allied views or statements which reflect the authoritative action of the ISMS or of reports on official actions, policies or positions. Views expressed by authors do not necessarily represent those of the Society; any connection with official policies is coincidental.

BRIEF SUMMARY
(For full prescribing information, see package circular.)
PREMARIN®
(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

PREMARIN®

BRAND OF CONJUGATED ESTROGENS TABLETS, U.S.P.

CONTAINS ONLY NATURAL ESTROGENS ...NO SYNTHETICS OR SUPPLEMENTS

Ayerst.

AYERST LABORATORIES
New York, N.Y. 10017

Clinics Slated For Crippled Children In July

Twenty-seven clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 21 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

July 2 Belleville—St. Elizabeth's Hospital
July 3 Hinsdale—Hinsdale Sanitarium
July 8 Peoria Cardiac—St. Francis Children's Hospital
July 9 Peoria—St. Francis Children's Hospital
July 9 East St. Louis—Christian Welfare Hospital
July 10 Joliet—St. Joseph's Hospital
July 10 Champaign-Urbana—McKinley Hospital
July 11 Sterling—Sterling Community Hospital
July 11 Effingham—St. Anthony's Memorial Hospital
July 11 Springfield—St. John's Hospital
July 11 DuQuoin—First Methodist Church
July 11 Macomb—McDonough District Hospital
July 11 Lake County Cardiac—Victory Memorial Hospital
July 12 Chicago Heights Cardiac—East Chicago Heights Community Center, Inc.
July 16 Quincy—Blessing Hospital
July 16 Rock Island—Moline Public Hospital
July 16 Decatur—Decatur Memorial Hospital
July 18 West Frankfort—Union Hospital
July 18 Elmhurst Cardiac—Memorial Hospital of DuPage County
July 22 Peoria Cardiac—St. Francis Children's Hospital
July 23 Peoria—St. Francis Children's Hospital
July 24 Rockford—St. Anthony's Hospital
July 24 Centralia—St. Mary's Hospital
July 24 Chicago Heights—East Chicago Heights Community Center, Inc.
July 24 Elgin—Sherman Hospital
July 26 Chicago Heights Cardiac—East Chicago Heights Community Center, Inc.
July 30 East St. Louis—Christian Welfare Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children. ◄

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied. ¼ grain; ½ grain; scored 1 grain; 1½ grain; scored 2 grain; 3 grain; and scored 5 grain tablets, in bottles of 100 and 1000.

Full information available on request.

WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

PR-GP-31-B/W



President's Page

It's Your Committee And It's Your Future

Logic and the evidence suggest that the Illinois State Medical Society faces a future clouded by animosity and divisiveness. And when I talk to colleagues, it is easy to sense a certain uneasiness about the unity of organized medicine in Illinois.

The reasons the ISMS future is less than bright are obvious. Given the deadly combination of polarization on the PSRO issue and discord on less prominent matters, we can predict with assurance an erosion or, perhaps, the destruction of our influence upon matters effecting our profession unless corrective action is taken.

The evidence for taking aggressive measures to repair our internal relations is by now overwhelming, the latest and most visible crisis being the decision by some component societies and their affiliated foundations to ignore the actions of the House of Delegates and seek federal PSRO planning grants.

Initially, the 1973 House of Delegates directive to implement a unified PSRO plan for Illinois evoked only a passive response from the membership. And even though the Illinois Professionals Standards Review Organization (IPSRO) was created in the midst of a literal barrage of PSRO publicity, the IPSRO concept went virtually unchallenged at the special House session last February and the annual meeting in April. Now, however, PSRO vs. IPSRO has become an emotional issue which threatens the future of ISMS. Where did we go wrong?

A select committee has been appointed by House Speaker Andrew Brislen, M.D., to answer that question and to study the organization, operation and governance of ISMS—a move unprecedented in the history of this society. The committee has been directed to thoroughly investigate the:

- Respective roles of and relationships between ISMS and component societies.
- Sources of conflict—on both professional and staff levels—between certain component societies and ISMS.
- Governance and organization of ISMS and its components—including consideration of:
 - *Advisability of creating regional societies to replace county societies in more sparsely populated areas.
 - *Redistricting and reapportionment of representation in the House of Delegates and the Board of Trustees.
 - *Tenure of officers, delegates, trustees and AMA delegates.
- Administration of the society's affairs including:
 - *Council and committee structure and responsibilities.
 - *Desirability of creating stronger district organizations and decentralizing some or all ISMS operations.
 - *Integration of activities of ISMS and county societies.
- Relationship of ISMS to Illinois Professional Standards Review Organization (IPSRO), Illinois Foundation for Medical Care (IFMC) and Illinois Council on Continuing Medical Education (ICCME), especially in regard to the role of ISMS in the governance of these satellites.

The recommendations which the select committee will present to the House of Delegates at next year's annual meeting are of monumental importance to this society, Therefore, they must reflect the views of the entire membership.

The future of ISMS hinges upon these recommendations and, ultimately, upon each of you. I urge you to assist in the appraisal and, perhaps, the restructuring of ISMS by submitting as soon as possible your observations, aspiration, suggestions and criticisms of this society to Committee Chairman and ISMS President-Elect J. M. Ingalls, M.D., 502 Shaw Avenue, Paris, Ill. 61944.

Without your involvement, the select committee faces a nearly impossible task, and ISMS faces a darkly clouded future.

Fredric D. Lake

Committee members are: Chairman, J. M. Ingalls, M.D., Paris; Drs. David Fox, Chicago; C. Larkin Flanagan, Chicago; Jack Gibbs, Canton; Robert Hartman, Jacksonville; Lawrence Hirsch, Chicago; Ross Hutchison, Gibson City; Richard Jones, Chicago; B. Franklin Lounsbury, Chicago; Jack Means, Mason City; Joseph Moles, Chicago; James Parsons, Geneseo; Ronald Staubly, Springfield, resident; Andrew Thomson, Evanston; Fred White, Chillicothe; and George Wilkins, Granite City. Student member is Alan Spector, Chicago. ◄

how to civilize the of peptic ulcer...

give pain killers?...prescribe frequent eating?...use antacids only

give pain killers only?

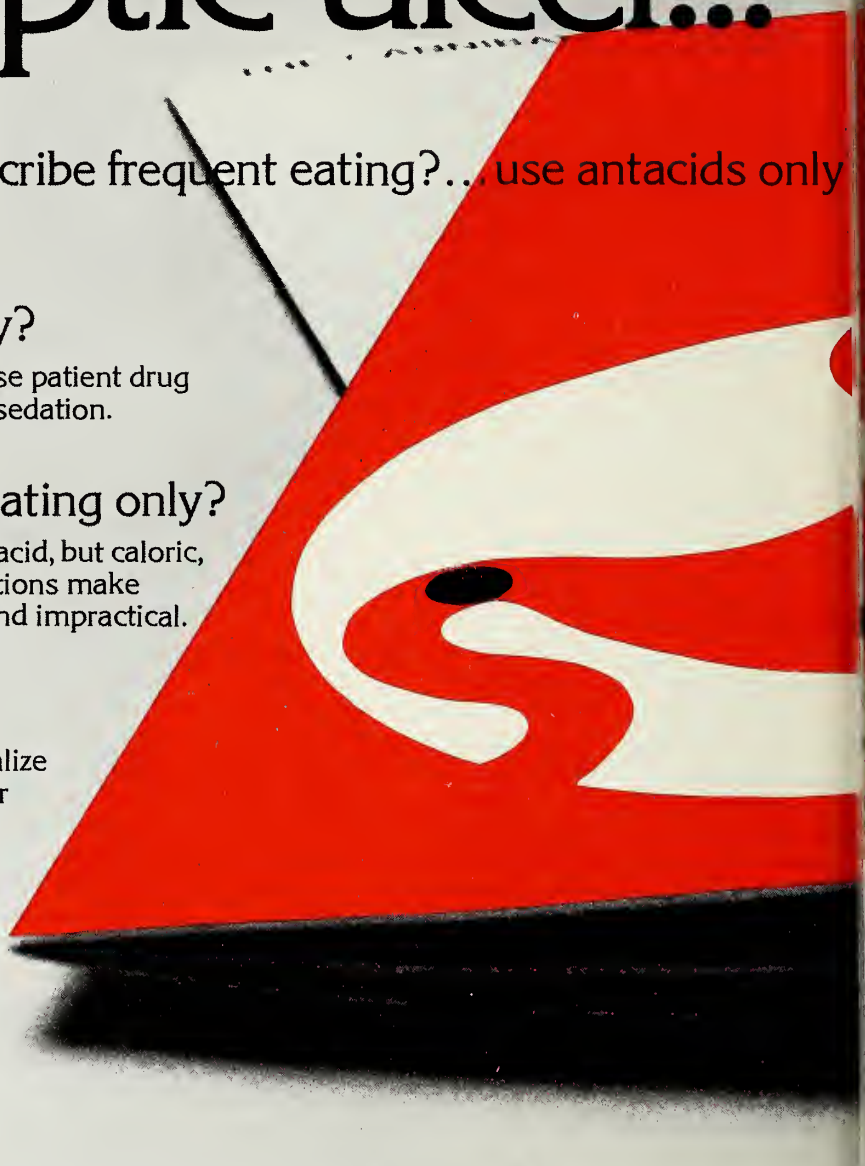
They relieve pain but may cause patient drug dependency and unnecessary sedation.

prescribe frequent eating only?

Frequent feeding helps buffer acid, but caloric, digestive, and social considerations make frequent eating both difficult and impractical.

use antacids only?

Antacids, like food, help neutralize or buffer stomach acidity. Their action is short, usually lasting only 1 to 1½ hours (given four hours after a meal).* Some patients may require antacids every half hour.



When you add Pro-Banthine® you

brand of
propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution.

Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may

or a package insert in many instances. This would constitute a substantial saving for the manufacturer.

By a complete compendium, do not mean a volume of prohibitive size. You don't need a book escribing 25,000 products with n enormous amount of repetition. ather, drugs should be arranged y class. Mutually applicable information would be provided, along ith brief discussions pinpointing ifferences in specific drugs of at class. Listings would be cross-ndexed in a useful way.

ther Available Documents as ources of Information

Existing references such as DR and the AMA Drug Evaluation e obviously useful but they are complete. Either they are not oss-referenced by generic name nd do not group drugs with simir characteristics, or they do not t all the available and legally arketed drugs. And some of ose omitted may be very useful. On the other hand, drugs made by more than one supplier, tetracycline for example, may be fully described a dozen times in the same book.

While perhaps PDR could be rearranged and cross-indexed with generics included, and while the AMA Drug Evaluation might also be modified and expanded, I am not sure that the end result would have all the attributes required for a useful compendium. At the same time, you would run the risk of amassing a voluminous and unwieldy tome.

Should Editorial Comments Accompany the Listings?

Subjective judgments, in my opinion, have no place in a compendium. However, if there is substantial evidence based on a sound body of science concerning relative efficacy of several drugs, certainly that information should be included. The committee of experts compiling and editing a particular section would also have to assess and indicate instances where a meaningful difference between drugs is pertinent.

Sponsorship, Compilation and Editing

Producing a book like this would undoubtedly be difficult and demanding. It would obviously take a great deal of talent and expertise, and would require a varied and experienced group, ranging from writers and editors to highly skilled clinicians and pharmacologists. Style, format and clarity of language would play an important part in determining the usefulness of the book. And it should be updated periodically and completely revised annually.

I have no opinion whether the government or the private sector should sponsor and/or finance the compendium. What is most important is that the compendium be an authoritative, objective and useful source of information for the doctor to have at hand as a ready reference.

ould in no way imply control over e practitioner's prerogatives.

hy Another Compendium?

A practicable, single-volume ompendium cannot, nor is it ecessary to, include all drugs on e market today. From my prace of internal medicine for some 5 years, my experience as a conltant, and as a faculty member four or five medical schools, I uld estimate that a doctor uses ly 30 to 35 drugs regularly. The 72 Physicians' Desk Reference, cidentally, contained about 500 entries.

As to whether there should be federal compendium, in my opinn, as stated earlier, the answer is sy—there should *not* be one. The oposal assumes that existing ompendia are inadequate. We're t sure of that at all. Whatever its perfections, the present drug formation system in the U.S. is en, multifaceted, pluralistic and tensive. Good compendia exist, well as other ample sources on ug therapy, ranging from journal erature through AMA Drug Evaluion to company materials. Not physicians may use such urces as often or as well as they ould, but that is the fault of the an, not of the sources.

In any event, rather than produce another book, it makes much more sense to work on improving existing compendia, and perhaps they could, as knowledge advances, include more accumulated clinical data and experience, and more information on drug interactions and adverse reactions.

Implications of a Federal Compendium

Take a hard look at the implications of a federal compendium. It would have the force of law, virtually dictating what drugs to use and how to use them. In effect, it would be a regulatory document with legal or quasi-legal status, posing medical/legal problems similar to those the doctor may now encounter if and when he departs from the provisions of the package insert. A compendium under federal aegis would tend to restrict decisions on drug therapy to one orthodox level—a most dangerous trend for medicine.

New Compendium—A Medical Option

I detect no ground swell of initiative or support whatsoever for a federal compendium—or, for that matter, for a new compendium of any type. A 1969 PMA survey conducted by Opinion Research Corporation found that only 15 per cent of those physicians interviewed felt a new compendium was needed. And a large majority did not favor the involvement of the federal government if one were to be created, preferring instead a nongovernmental consortium.

Even if we come to a time when the medical profession itself opts for a new kind of compendium, it should be handled and financed, ideally, outside both government and industry. Final review and editorial authority could be delegated, say, to specialty bodies and medical societies—but above all, *not* the government.

Surely the health care system in the United States has far more vital matters to consider than the extensive cost and effort that would have to go into the preparation and maintenance of a new, monolithic compendium, and especially one bearing the imprimatur of the federal government.

Opinion & Dialogue

What is your opinion, doctor? We would welcome your comments.

The Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



ILLINOIS
Medical Journal

The Official Organ
of the
State Medical Society

A Monthly Bulletin
Edited by the
Publication Committee

Printed by
THE ILLINOIS STATE JOURNAL COMPANY.

Entered in the Springfield Postoffice as Second-Class Matter.

Volume XLIX.
Number 1.

Ottawa, July, 1899.

Subscription, $3 a Year.
Single Copies, 25 Cents.

TABLE OF CONTENTS.

ORIGINAL ARTICLES.

President's Address—Currents and Counter-Currents in Medicine—T. J. Pitner, M. D., Jacksonville 3

Stomatitis Materna—Jacob Schneck, M. D., Mt. Carmel 9

A Newer Pathology of Epilepsy—Daniel R. Brower, A. M., M. D., LL. D., Chicago.... 12

Journalizing the Transactions—George N. Kreider, A. B., M. D., Springfield..... 17

Vesicular Degeneration of the Chorion—Carl E. Black, M. D., Jacksonville..... 30

EDITORIALS.

Announcement 34

Some Comparisons..... 35

Of Assistance to Legislative Committee ... 36

Proceedings of Cairo Meeting..... ... 14

BIOGRAPHIES.

J. B. Hamilton..... 22

J. H. Etheridge..... 24

B. M. Griffith..... 26

W. M. Catto 27

M. Rooney..... 27

Ella M. Patton 29

A. J. Morton..... 29

Correspondence—C. E. Black, M. D., Jacksonville..... 36

Society News..... 38

State Items..... 40

List of Members Attending Cairo Meeting. 43

Chicago News Items..... 44

Medical Societies of Illinois 46

Officers of State Society..... 48

History of the Illinois Medical Journal

The *Illinois Medical Journal* is having its 75th birthday this year, being the second oldest state medical journal. In 1899, at the Cairo, Ill. meeting, the House of Delegates voted to begin a journal. G. N. Kreider, M.D., of Springfield, strongly believed that a journal was needed so that all practitioners could be reached more readily and more often. His prediction that it would help to increase the total membership numerically and educationally was correct. There were at the time 8,000 physicians in Illinois but, only 540 were members and, of these, 260 were delegates to the House.

Not surprisingly, Dr. Kreider became the first *IMJ* Editor. In 1900, the circulation was 1,250 and by 1904, it had increased to 4,500 and the average issue contained 132 pages. Dr. Kreider's prediction came true in that membership in the Illinois State Medical Society increased some 40% each of the first two years of publication.

Initially the *Journal* incurred a deficit. This changed when advertising was accepted in 1901. By 1905, it was possible to lower the subscription price from $3.00 to $2.00. Since its beginning, the *Journal* has continued to be a truly representative spokesman for the medical community in Illinois.

The history of the *Journal* does not go back as far as the Illinois State Medical Society. For almost a century, the formation of the Illinois State Medical Society was believed to have taken place on June 4, 1850. Then, in 1937, the late Lucius H. Zeuch, M.D., showed that the society actually began in 1840. The 1850 meeting seems to have been a reorganization of an existing but, perhaps, dormant Society. The American Medical Association assembled in 1847 and the Chicago Medical Society was established in 1850.

In the decades preceding the birth of the *Illinois Medical Journal,* the physicians of this area were not without a journal. There was the *Illinois Medical* and *Surgical Journal* that served Illinois, Michigan, and the territories of Wisconsin and Iowa. Founded in 1844 by James Van Zandt Blaney, M.D., a faculty member of Rush Medical School, it had a continuous existence for 45 years, becoming successively, the *Illinois and Indiana Medical Journal,* the *Northwestern Medical and Surgical Journal,* the *Chicago Medical Journal,* and finally, the *Chicago Medical Journal and Examiner.* Publication was stopped in 1889. Incidentally, the *Journal of the American Medical Association (JAMA)* did not come into being until 1893.

Dr. Kreider remained as Editor of the *Illinois Medical Journal* until 1913 when Clyde Pence, M.D., took over. In 1919, Charles G. Whalen, M.D., became Editor and served in this capacity until his death in 1941. Harold M. Camp, M.D., then Secretary-Treasurer of the ISMS, took over the helm. At Dr. Camp's death in 1959, your present editor was elected to continue the work of these dedicated men.

T. R. Van Dellen, M.D.
Editor

Currents and Counter Currents in Medicine in 1899

In 1899, T. J. Pitner, M.D., Jacksonville, gave his presidential address to the Illinois State Medical Society delegates and residents at Cairo (location of the annual meeting). The new ISMS President spoke on the "Currents and Counter Currents in Medicine." His inaugural address appeared in the first issue of the *Illinois Medical Journal,* July, 1899.

One of Dr. Pitner's main concerns was quackery, a primary reason for the establishment of the Illinois State Medical Society in 1840. This subject still is of great concern 134 years later. He examined extensively the isms, fads and fraud practices of osteopathic medicine, eclecticism and Christian Science. Chiropractic had been founded only four years previous and apparently

was not known at that time.

"The masses of the people are ignorant and easily deceived in regard to the nature of disease and means of cure. What they want is relief, no matter from what source it may come. They submit to those who pretend most and promise most. There is no field so rich for the imposter as this people, taken in by extravagant preventions and the most positive promises of cure, with all the wiles and tricks for impressing and deceiving their victims so well known and skillfully plied by the whole tribe of quacks," stated Dr. Pitner.

In the area of medical education, Dr. Pitner noted that the requirements for graduation in medicine had doubled the standards 20 years ago (1879). In 1899, Illinois schools required four years of medical school versus the previous two years of study with attendance of lectures for five to six month duration. Changes were brought about due to the influence of the Illinois State Board of Health refusing to recognize diplomas of colleges whose standards were below that which was required of medical colleges to be in good standing.

Medical Journalism in Illinois*

Up to 1844, there had been 509 medical journals in the United States, of which 136 were surviving. The rise of medical publications in Illinois in the period of 1885 to 1900 reflected the numerous medical schools and various forms of cultism and quackery that prevailed.

In 1844, the *Illinois Medical and Surgical Journal* became the first, and, for several years, the only medical journal serving Illinois, Indiana, Michigan and areas of Wisconsin and Iowa. Dr. James Van Zandt Blaney, member of the Rush Medical College faculty, served as Editor; it was his hope that this publication would introduce Western U.S. medicine to Eastern U.S. physicians. Dr. Nathan S. Davis, active in organizing the Illinois State Medical Society and the American Medical Association, served as Editor in 1855. The *IMSJ* existed for 45 years becoming successively the *Illinois and Indiana Medical Journal,* the *Northwestern Medical and Surgical Journal, the Chicago Medical Journal* and *the Chicago Medical Journal and Examiner.*

When Dr. Davis was Editor of the *Northwestern Medical and Surgical Journal,* soon to be the *Chicago Medical Journal,* he was asked by the Illinois State Medical Society to publish its transactions. Due to political struggles in medicine of the Midwest and the battle of the homeopaths for recognition and publishing their principles, it was important that the state society have its actions in print.

For 15 years, Drs. N. S. Davis and E. A. Steele served as Editors of the *Chicago Medical Examiner.* Dr. Davis and other members of the faculty at Rush Medical College became disenchanted when Dr. Daniel Brainard vetoed certain recommedations made by the American Medical Association. The former Rush faculty members formed the Medical Department of Lind University and the *Chicago Medical Examiner* served as the organ of the new school. This periodical contained abstracts of the proceedings of the Chicago Medical Society, the Chicago Academy of Medical Sciences and the Illinois State Medical Society.

Cult Publications

During this era, the days of homeopathy and eclecticism, publications were flooding the market. Dr. George Shipman of Chicago was the leader of homeopathy and served as Editor of *Northwestern Journal of Homeopathia,* 1848-1852; the *American Journal of Materia Medica,* 1860-1861; the *Medical Investigator,* 1860-1863 and the *United States Medical and Surgical Journal,* 1865-1869.

The *Medical Investigator,* an organ of homeopathy from 1861-1874, consolidated in 1875 to become the *United States Medical Investigator.* Dr. Thomas Cation Duncan, Secretary of the Illinois Homeopathic Medical Association was its Editor.

The *American Homeopath* was published in Chicago from 1878-1880 and the *Homeopathic Record* in 1878. *Clinque* was a monthly published by the Illinois Homeopathic Medical Association which ran from 1880-1926.

The *Chicago Medical Times* appeared in 1869 under the editorship of Drs. John Forman and

*Excerpts taken from "Medical Journalism in Illinois," History of Medical Practice in Illinois, Vol. II, 1850-1900, pp. 480-488.

R. A. Gunn. Dr. Forman was Dean of the faculty and Professor of Anatomy and Clinical Medicine of the Bennett College of Eclectic Medicine and Surgery that opened in Chicago in 1868. Dr. Gunn was Professor of Surgery at the same school. Successively the Editors were: Drs. R. A. Gunn, J. A. Hurlbut, A. L. Clark, W. H. Davis and P. Ellingwood. The *Chicago Medical Times* merged into the *American Journal of Clinical Medicine,* becoming abbreviated to *Clinical Medicine and Surgery* in 1894. From 1894-1905, the magazine became *Alkaloidal Clinic,* under the direction of Dr. W. Abbott; from 1906-1924, this publication became the *American Journal of Clinical Medicine* and later *Clinical Medicine,* 1924-1926.

The *Illinois State Eclectic Medical Society Journal* appeared as transactions published in Springfield in 1883.

The Journal of the American Medical Association

The first issue of the *Journal of the American Medical Association (JAMA)* was published in July, 1883. Dr. N. S. Davis, Illinois, Chairman of the AMA Board, was named Editor-in-Chief.

Soon a battle occurred among the AMA leaders as to the location of the publishing headquarters. Some physicians endeavored to move the magazine to the East coast; but, Chicago maintained admidst the years of personal journalism fighting.

Geographic Publications

Some of the geographically oriented publications included the *Monthly Journal of the Southern Illinois Medical Association,* established in Cairo, 1877; the *Illinois Medical Recorder,* a monthly publication under the auspices of the District Medical Society of central Illinois, 1878-1879; *Peoria Medical Monthly,* 1880-1890; and *Medical Call,* published in Quincy, Ill., 1881-1888.

The *Interstate Medical Journal* began in 1894 as the organ of the Tristate District Medical Association, continued under the Interstate Postgraduate Medical Association of North America, and later, in 1919, becoming *Modern Medicine.*

Plexus was published by the Medical Department of the University of Illinois for the College of Physicians and Surgeons during 1895-1913.

The need to alert the physicians in Illinois of the existence and purpose of the Illinois State Medical Society brought about the publication of the first volume of the *Illinois Medical Journal,* 1899. That year the ISMS assembly in Cairo voted to begin the *IMJ* with Dr. George Kreider as Editor; the second state medical journal, its publication increased membership of the state society some 40% during the first few years of publication. (For more detail, see Editorial, page 485.)

The *Illinois Medical Journal* has survived during two World Wars, a depression and periods of socio-economic unrest. It strives to serve the Illinois physicians in various capacities. Not only has the *IMJ* strengthened the membership by serving as the ISMS official organ, but it has been a strong tool for continuing medical education. A variety of clinical subjects are included in the monthly issue to keep physicians abreast on latest techniques and discoveries. *IMJ* is proud to have published many rare, and "first documented" case reports.

75 Years Ago...

When the first volume of the *Illinois Medical Journal* appeared in July, 1899, the *Chicago Daily Tribune* carried stories on yellow fever; an African plague; Fourth of July casualties; surgery in cinematography; and the first automobile used as an ambulance.

Principal hotels in Santiago, Cuba, were infected with yellow fever. July 5, 1899, reported 4 new cases with two deaths in Cuba. One of the yellow fever victims was Maj. Joseph Heatwell from Indiana.

The same *Tribune* issue reported an epidemic at Grand Bassain, a French Ivory Coast colony. The African disease was similar to the bubonic plague of India. To that date, over 300 persons had been afflicted, including three physicians, and 27 deaths.

"Havoc of the Fourth" was bannered. In the

nation there were over 1,070 persons injured due to Fourth of July celebrations, which caused three deaths. One death occurred in Chicago when a child was playing with a toy cannon. There were 53 injuries in the Chicago vicinity.

A French surgeon, Doyen, distinguished for swiftness and certainty of his stroke, became dissatisfied with clinical demonstrations. So, he had special cinematography made through the application of instantaneous photos of a variety of operations.

A Chicago merchant returning from Europe became ill; upon the docking of the ship at a New York pier, the merchant was taken to a New York hospital in an automobile. This event, on July 9, 1899, is believed to be the first time an automobile was used as an ambulance.

Oldest Living Illinois Physician

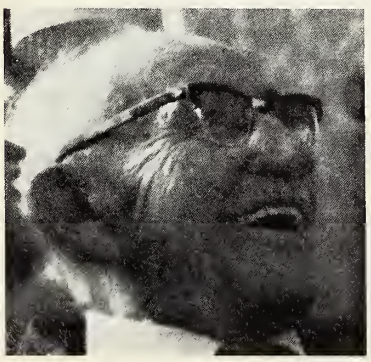
The Remarkable Dr. Hill

Editor's Note: *The Illinois Medical Journal* sent a staff member to interview Dr. Hill; this is an account of that meeting.

In the spring of 1898, Tolbert F. Hill, M.D. set up his medical practice in Athens, population of 1000. The rural community, located outside of Springfield, 76 years later, is proud to have Dr. Hill still as a resident and physician. Last January, Dr. Hill became a "legend" when he marked his 100th birthday, making him the oldest living Illinois physician. His medical career parallels the history of the *Illinois Medical Journal.*

Dr. Hill's children, Dr. Harold Hill, San Jose, Calif., and Mrs. Henry (Louise) Winterbauer, Chicago, held an open house to commemorate the century birthday. Over 290 birthday greetings were received by Dr. Hill, including those from President Nixon, Senator Charles Percy, Governor Walker, State officials, and Rev. Billy Graham, to mention a few. Family, friends and former patients came to pay tribute to the town's "only physician."

He is remembered by his former patients throughout the year. Mrs. Belle Berry, his housekeeper for the past 14 years, recalls one summer day when a mysterious government car with Oregon license plates pulled up in front of Dr. Hill's home. The occupant of the car asked to see Dr. Hill. "Come to find out, this man was celebrating his 60th birthday and he wanted to visit with the physician who had brought him into the world and had given him his first spanking," relates Mrs. Berry.



A frequent visitor of Dr. Hill's is a young woman in the Athens vicinity who was delivered by Dr. Hill on his birthday.

"This town has honored me with everything except Constable," stated Dr. Hill in a recent interview. Dr. Hill was speaking of the many honors and tributes that the community has paid to him as the Mayor, President and Director of the Athens State Bank for 41 years, and member of the Board of Education. He has a large collection of plaques, silver trays and tokens for his years of civic service.

A Family of Physicians

Tolbert F. Hill was the youngest of five sons born to Dr. and Mrs. Green (Martha Caldwell) Hill, Middletown. At the birth of Tolbert, the southern gentleman father was 60 years of age. Tolbert recalls stories of his father making acquaintance with Abraham Lincoln, and how, since the good doctor was a staunch Democrat, this caused some excitement.

Green Hill came from Tennessee in 1850 to serve the people in central Illinois. Since he was the only physician for many miles, he traveled extensively on horseback to serve the people. Often he was paid in kind as money was scarce.[1]

The five sons of Green Hill all became physicians. Tolbert graduated from Rush Medical School in three years. Keeping medicine in the family, Dr. Hill's son, Harold, became a physician. He graduated from the University of Illinois College of Medicine and is presently practicing in San Jose, Calif.

A fourth medical generation of Hill's is being carried on with grandson R. J. Winterbauer. Dr. Hill proudly talks about the time he and Mrs.

Hill went to see their grandson play quarterback for Yale University. When his grandson entered medical school at Johns Hopkins University, Dr. Hill presented him with first editions of books by Sir William Osler (1849-1919), best known for his PRINCIPLES AND PRACTICE OF MEDICINE.

The Horse and Buggy Doctor

When Dr. Hill moved to Athens, the town had streets made of white pine, which had to be watered to keep the dust down. In 1899, he married the former Lettie Herrin of Buffalo, and to this marriage two children were born. Dr. Hill often traveled many miles to court his lady and enjoyed taking chocolates to her. Mrs. Hill passed away in 1955, and soon afterward, Dr. Hill entered retirement. During their many years of marriage, they always had time for traveling and their family.

His daughter recalls making calls with her father when he would charge only $1.00-2.00. "As we would ride along in the horse and cart, Dad would identify all of the bird calls; he loves nature," tells Mrs. Winterbauer.

Recalling what it is like to be the only town doctor, Dr. Hill remembers how he had to act instantaneously when a woman would have difficulties or hemorrhage while giving birth at home. "It was solely up to me to make the right decisions and procedures in emergency situations," relates Dr. Hill.

Of the 2500 babies Dr. Hill has brought into the world, he remembers delivering one 12 pound baby and several sets of twins. He also delivered his own children at home.

On many occassions Dr. Hill served as the town dentist. Amused by a past happening, Dr. Hill tells about the time when a man came to have a tooth pulled, and with no anesthetic, Dr. Hill started to pull, but was unable to have enough grip to get the tooth out; so the patient, who was strong and big, reached up and grasped Dr. Hill's arm, and together they got the tooth out.

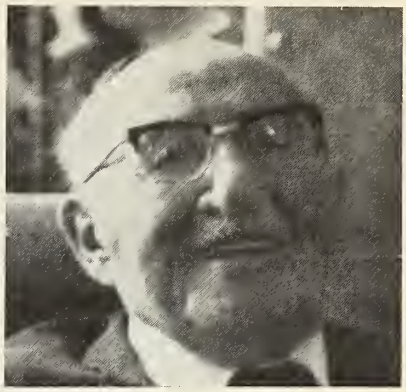
Dr. Hill dispensed medicine before pharmacies became available in nearby towns. He still maintains the medicine cabinet he had in his office.

"I had no worry about malpractice as doctors today do. It wasn't until the last years of my practice that I carried professional liability insurance," says Dr. Hill.

"There isn't the intimacy between a doctor and his patients anymore, and this is unfortunate," continues Dr. Hill.

Dr. Hill is presently an honorary staff member of St. John's Hospital in Springfield. During his affliation with St. John's, he has seen three different renovative phases.

"I've had a good life"



Life at 100

At the age of 100-years, Dr. Hill maintains good health. He enjoys his five grandchildren and nine great-grandchildren.

The witty physician likes to read in his favorite room of the house, which he had built for his family. His sitting room consists of a roll top desk and the medicine cabinet that he had in his office, plus his reading chair.

Residents of Athens can see the agile Dr. Hill make his daily jaunt to the Post Office to pick up his *Chicago Tribune*. This past winter he was seen shoveling snow. He takes pleasure in his big yard, accented with a large blue spruce tree.

A few weeks ago the devoted physician made a call to the Illinois Department of Registration and Education inquiring as to whether or not, at his age, he had to renew his license; his inquiry was most rare.

He is a member of the Sangamon County Medical Society, who honored him last January upon his 100th birthday. In 1947 he became a member of the Fifty Year Club of the Illinois State Medical Society, which is an elite group of ISMS member physicians who have practiced for 50 years; presently he holds the title of "Dean of the Fifty Year Club," being the oldest living member.

"I have had a good life," states Dr. Hill. And he has helped many central Illinois residents have a good, healthy life, too. Residents for many years to come will recall this man who served as an arbitrator, counselor, friend, civic leader and above all, a physician.

Reference

1. "History of Logan County," HISTORY OF ILLINOIS, Inter-State Publishing Co., Chicago, 1886.

Personal Dedications Guide Physicians

Editor's Note: Over the years, medicine has progressed from a rudimentary form of nursing to a highly sophisticated, refined treatment of human illness. Early in the Nineteenth Century, Illinois was peopled by native Americans and a few hardly colonial pioneers. Settlement and change, discoveries through research and serendipity, and pure, gutsy hard work evoked the Illinois we know today, and current medical technique and technology as well.

ISMS itself numbers some 134 years and the *Illinois Medical Journal,* at 75, is still a sprightly, fresh means of reflecting educational as well as organizational items for the elucidation and edification of the membership.

Many brief items in this issue reflect back to yesteryear when the *IMJ* was born, and recount some of the events of those times.

In this context, the various personal dedications to which physicians ascribe come to mind. These each reflect the basic tenets and principles for which men of medicine stand. Over the years, the Oaths and Declarations have provided the guidance necessary to conduct the affairs of medicine. They are reprinted here for the reader's contemplation and remembrance. May these continue to guide medicine in the future in its quest for health care of the highest quality for all people.

The Oath of Hippocrates

I swear by Apollo, the physician, and Aesculapius and health and all-heal and all the Gods and Goddesses that, according to my ability and judgment, I will keep this oath and stipulation:

TO RECKON him who taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none others.

I WILL ALLOW that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; futhermore, I will not give to a woman an instrument to produce abortion.

WITH PURITY AND WITH HOLINESS I will pass my life and practice my art. I will not cut a person who is suffering from a stone, but will leave this to be done by practitioners of this work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption; and further from the seduction of females or males, bond or free.

WHATEVER, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad I will not divulge, as reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this oath unviolated may it be granted to me to enjoy life and the practice of the art, respected by all men at all times but should I trespass and violate this oath, may the reverse be my lot.

Declaration of Geneva

Adopted by the General Assembly of the World Medical Association at Geneva, Switzerland, September, 1948.

AT THE TIME OF BEING ADMITTED AS MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE myself to consecrate my life to the service of humanity.

I WILL GIVE to my teachers the respect and gratitude which is their due.

I WILL PRACTICE my profession with conscience and dignity.

THE HEALTH OF MY PATIENT will be my first consideration.

I WILL RESPECT the secrets which are confided in me.

I WILL MAINTAIN by all means in my power, the honor and the noble traditions of the medical profession.

MY COLLEAGUES will be my brothers.

I WILL NOT PERMIT considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.

I WILL MAINTAIN the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I MAKE THESE PROMISES solemnly, freely, and upon my honor.

Prayer of Maimonides

Almighty God, You have created the human body with infinite wisdom. Ten thousand times ten thousand organs You have combined in it that act unceasingly and harmoniously to preserve the whole in all its beauty—the body which is the envelope of the immortal soul. They are ever acting in perfect order, agreement and accord. Yet, when the frailty of matter or the unbridling of passions deranges this order or interrupts this accord, then forces clash and the body crumbles into the primal dust from which it came. You send diseases to man as beneficent messengers to foretell approaching danger and to urge him to avert it.

In Your Eternal Providence You have chosen me to watch over the life and health of Your creatures. I am now about to apply myself to the duties of my profession. Support me, Almighty God, in these great labors that they may benefit mankind, for without Your help not even the least thing will succeed.

Inspire me with love for my art and for Your creatures. Do not allow thirst for profit, ambition for renown and admiration, to interfere with my profession, for these are the enemies of truth and they can lead astray in the great task of attending to the welfare of Your creatures. Preserve the strength of my body and of my soul that they ever be ready to help rich and poor, good and bad, enemy as well as friend. In the sufferer let me see only the human being. Illumine my mind that it recognize what presents itself and that it may comprehend what is absent or hidden. Let it not fail to see what is visible, but do not permit it to arrogate to itself the power to see what cannot be seen, for delicate and indefinite are the bounds of the great art of caring for the lives and health of Your creatures. Let me never be absent-minded. May no strange thoughts divert my attention at the bedside of the sick, or disturb my mind in its silent labors, for great and sacred are the thoughtful deliberations required to preserve the lives and health of Your creatures.

Grant that my patients have confidence in me and my art and follow my directions and my counsel. Remove from their midst all charlatans and the whole host of officious relatives and know-all nurses, cruel people who arrogantly frustrate the wisest purposes of our art and often lead Your creatures to their death.

Should those, who are wiser than I wish to improve and instruct me, let my soul gratefully follow their guidance; for vast is the extent of our art. Should conceited fools, however, censure me, then let love for my profession steel me against them, so that I remain steadfast without regard for age, for reputation, or for honor, because surrender would bring to Your creatures sickness and death.

Imbue my soul with gentleness and calmness when older colleagues, proud of their age, wish to displace me or to scorn me or disdainfully to teach me. May even this be of advantage to me, for they know many things of which I am ignorant, but let not their arrogance give me pain. For they are old and old age is not master of the passions. I also hope to attain old age upon this earth, before You, Almighty God!

Let me be contented in everything except in the great science of my profession. Never allow the thought to arise in me that I have attained to sufficient knowledge, but vouch-safe to me the strength and the ambition ever to extend my knowledge. For art is great, but the mind of man is ever expanding.

Almighty God! You have chosen me in Your mercy to watch over the life and death of Your creatures. I now apply myself to my profession. Support me in this great task so that it may benefit mankind, for without Your help not even the least thing will succeed. ◄

Kefzol®
cefazolin sodium

Ampoules, equivalent to 1 Gm. of cefazolin



Additional information available to the profession on request.

Eli Lilly and Company
Indianapolis, Indiana 46206
400380

IMJ
Illinois Medical Journal
Vol. 145, No. 6, June, 1974

Clinical Variations of Cystic Fibrosis

By Daniel G. Cunningham, M.D./Oak Lawn

It is estimated that cystic fibrosis affects approximately one of every 2,000 white children born in the United States, and is now generally regarded as the commonest serious metabolic disorder of white children with the exception of diabetes mellitus.[1] Its occurrence in children of Afro-Americans is quite rare and exceedingly so in those of Oriental extraction. Since cystic fibrosis is genetically determined as an autosomal recessive trait,[2] and since the obligate heterozygote parent is entirely asymptomatic, the disease on its first occurrence in a given family can only be suspected by its manifestations in the patient himself. At present there is no test available for the detection of cystic fibrosis which can be applied as a simple, practical screening test, such as is available for phenylketonuria. Diagnostic tests are, therefore, used to confirm or refute the diagnosis of cystic fibrosis when suggestive symptoms arise or when a sibling or relative is known to have the disease.

Sweat Testing

One of the invariable features of cystic fibrosis is the patient's inability to reabsorb sweat electrolytes and an elevation of Na^+ and Cl^- in sweat constitutes a diagnostic test in children.[3] Conditions which are likely to be confused with cystic fibrosis on the basis of sweat electrolytes are unlikely to present any clinical diagnostic confusion. Therefore, for practical purposes, the finding of significantly elevated Na^+ and Cl^- in the sweat is diagnostic of cystic fibrosis.[4-6] Since the elevated levels of Na^+ and Cl^- tend to parallel one another quite closely, it is sufficient to measure only one of these electrolytes. In normal individuals the electrolyte concentrations of sweat increase with age, and thus the standards used in childhood do not necessarily apply to an adult population. At the present time, one should regard the sweat test as being the only test available by which the diagnosis of cystic fibrosis can be made with accuracy, and any facility caring for patients with this disease should have the capability of performing such testing on patients of all age groups including neonates. The vast majority of healthy children have sweat Na^+ and Cl^- levels of less than 40 milliequivalents per liter although somewhat higher levels are sometimes encountered. Levels above 70 mEq/L are diagnostic of cystic fibrosis in childhood, and normal children never exhibit levels in this range.

The purpose of this paper is to discuss the indications for sweat testing or to attempt to answer the question, "When does one suspect



DANIEL G. CUNNINGHAM, M.D., is an Associate Professor of Pediatrics at Rush Medical Schaal and is Program Directar af Pediatrics at Christ Community Hospital, Oak Lawn. At the time of writing this article, Dr. Cunningham was Director of the Cystic Fibrosis Clinic and the Pediatrics Out Patient Department at Loyola Medical Center. Dr. Cunningham is a graduate of the National University of Ireland.

cystic fibrosis?"

In an attempt to answer this question, one can classify the symptoms of cystic fibrosis under the following headings:

1. Gastrointestinal Manifestations
2. Cirrhosis of the liver
3. Pulmonary Manifestations
4. Nasal Polyposis

Gastrointestinal Manifestation: The gastrointestinal symptoms exhibited by patients with cystic fibrosis reflect the absence of pancreatic enzymes with resultant maldigestion of fats and protein. About 20% of patients with cystic fibrosis have adequate pancreatic function and thus have no gastrointestinal manifestations. Fifteen percent of cystic fibrosis patients present with meconium ileus at birth exhibiting intestinal obstruction at the level of the terminal ileum.[7] Meconium ileus is frequently associated with perforation, meconium peritonitis, volvulus, atresia or other intra-abdominal complications, all of which are indications for prompt surgical intervention. All patients with meconium ileus have total pancreatic achylia.

The steatorrhea resulting from lipase deficiency may manifest itself in many different ways.[8] Some infants may have frequent loose stools, often foamy and oily. Clinically these patients may resemble those with milk allergy or disaccharidase deficiency. In others, the frequency of stools may be unremarkable, but the character of the stool may be quite striking; bulky, offensive to the smell, and floats in water. Such cases resemble gluten enteropathy or uncommon syndromes such as a-beta lipoproteinemia, primary lipase deficiency or the Shwachman syndrome.[9] The sweat test clinches the diagnosis of cystic fibrosis. Prolapse of the rectum is a frequent complication of cystic fibrosis, but fortunately usually responds without recurrence to adequate enzyme replacement. Cystic fibrosis is the commonest cause of rectal prolapse in the white child. The following brief case history illustrates this presentation of cystic fibrosis.

Case Histories

A seven-year-old patient was referred to the Cystic Fibrosis Clinic for sweat testing because of recurrent respiratory infections and episodes of respiratory distress suggestive of bronchial asthma. Her mother did not regard her bowel habit or stools as being in any way strikingly different from those of her siblings. However, she had recurrent rectal prolapse from early in her first year of life. The suspicion of cystic fibrosis was further strengthened by the presence of a mucoid nasal polyp. Chest X-ray revealed mild peribronchial fibrosis. Sweat sodium was 118 milliequivalents per liter. Enzyme therapy resulted in the prompt disappearance of her prolapse.

Untreated pancreatic enzyme deficiency with resultant malabsorption is usually associated with failure to gain weight in spite of good or even ravenous appetite. Thus, cystic fibrosis should be considered in the differential diagnosis of all infants who fail to thrive, particularly if gastrointestinal or respiratory symptoms exist. In association with fat malabsorption, there may be secondary deficiencies of fat soluble vitamins.[10] This is especially true of Vitamin K, and all patients with cystic fibrosis should have prothrombin studies before surgical procedures and Vitamin K therapy if necessary.[11] Interestingly, rickets is not a feature of cystic fibrosis.

Severe degrees of hypoproteinemia are sometimes seen in untreated cystic fibrosis. Such patients have pancreatic achylia with the symptoms described above, but the clinical features of steatorrhea may be overshadowed by those of protein deficiency, primarily because of protein maldigestion due to the absence of pancreatic proteolytic enzymes. Occasionally, massive edema and ascites are seen which respond to enzyme therapy. Such clinical findings in themselves are indications for sweat testing as demonstrated in the following brief case presentation.

A boy of 18 months never had respiratory symptoms and, in spite of a voracious appetite, he failed to gain weight satisfactorily—being smaller than his siblings in weight and height, age adjusted. Over a short period of time before his first hospital admission, he became increasingly pot-bellied. He was found to have massive ascites, and his serum proteins were less than 2 gm per 100 cc. The diagnosis of cystic fibrosis was confirmed by sweat testing. His ascites disappeared with enzyme therapy. At this point it became apparent that his liver was hard, with irregular edges, and that his spleen was also enlarged. Liver enzymes and alkaline phosphatase levels were elevated.

This child had cystic fibrosis with hypoproteinemia, ascites, and edema secondary to protein maldigestion. He also had cirrhosis of the liver. While his hypoproteinemia will disappear with enzyme therapy, the progress of his liver involvement can only be determined by long-term observation and study.

Liver Disease: In a minority of patients, perhaps 5% of all patients with cystic fibrosis, biliary

cirrhosis dominates the clinical picture.[8] This is especially true in the older pediatric age group. Such patients have hepatomegaly with varying degrees of biochemical abnormality. The lesion is progressive, proceeding to portal hypertension, sometimes with hypersplenism.[12] Bleeding from esophageal varices is the most frequent terminal event. However, in any given patient with cystic fibrosis, the disease may have multiple system involvement especially in the older age groups and thus, the patients with cirrhosis will also have varying degrees of pulmonary involvement. Uncommonly, cystic fibrosis presents with the clinical picture of prolonged cholestatic jaundice in the early months of life mimicking neonatal hepatitis or biliary atresia. This condition subsides in a few months.

While liver involvement is clinically apparent in only a small percentage of patients, the incidence is much higher from the point of view of the pathologist. Hepatic changes can be seen in one fifth of cystic fibrosis patients at autopsy. It is reasonable to state that sweat testing for cystic fibrosis has a significant role in the diagnostic work-up of patients with liver disease particularly if other symptoms of cystic fibrosis exist.

Respiratory Involvement: From the clinical point of view, the most important aspects of cystic fibrosis are those related to the lung and bronchial tree since it is in this area that the major problems of management exist. The prognosis in the vast majority of cystic fibrosis patients depends on the severity of their pulmonary involvement. One could regard the pulmonary involvement of cystic fibrosis as being secondary to abnormal mucus production in the bronchial tree rather than as a primary lung disease. The mucus secreted in the cystic fibrosis patient is abnormal in quality and quantity, resulting in the production of larger than normal quantities of abnormal mucus.[1] Mucus obstruction of the lumen and metaplastic changes in the epithelium results in chronic obstructive lung disease. In early life, this manifests itself as recurrent infection. Initial episodes present with the clinical picture of pneumonia, bronchiolitis, or bronchitis.

In past decades, most patients with cystic fibrosis succumbed in their early months or years from bacterial pneumonia, often staphylococcal. With more frequent recognition of their underlying disease, better nutrition because of its treatment and the availability of effective antibiotics, the mortality rate of cystic fibrosis patients has been reduced dramatically in the early years allowing the majority of patients to survive into their late teens, 20's, or longer. However, pulmonary infections constitute a trying therapeutic problem in many young patients especially in the first year of life because of their tendency to harbor pseudomonas aeruginosa organisms. The association of pseudomonas infections of the lung with cystic fibrosis is well known and poorly understood.[13,14] The time at which the cystic fibrosis patients become colonized by pseudomonas will vary greatly from one to another, but very few ultimately escape this phenomenon. Unfortunately, once pseudomonas infection occurs in the respiratory tract of a child with cystic fibrosis, it is very rarely eradicated even with modern drug therapy.

The bronchiopulmonary lesion of cystic fibrosis is progressive. Obstruction and metaplasia lead to infection, fibrosis and bronchiectasis. Ultimately, this is complicated by pulmonary hypertension, bronchial vascular hypertrophic changes, respiratory insufficiency and bleb formation. In older patients, dramatic complications such as pneumothorax and massive pulmonary hemorrhage may occur requiring emergency treatment as exemplified in the following brief case presentation.[15,16]

Case Report

A 15-year-old girl known to have cystic fibrosis since early childhood first presented to Loyola in acute respiratory distress and cyanosis of rapid onset. Chest X-ray first showed a large pneumothorax left side, advanced pulmonary fibrosis, many large apical blebs and evidence of active parechymal infection. Following tube thoracostomy, she improved dramatically. Sputum cultures grew pseudomonas aeruginosa. She was hospitalized for three weeks, received intensive therapy and was discharged on antibiotics, physical therapy and inhalation therapy.

Two years later, she leads an active life, loses little time at school and is being seen at regular intervals in the Loyola Cystic Fibrosis Clinic.

The above is an example of the advanced picture of cystic fibrosis and is fairly typical of the picture seen in many patients in this age group who can lead very active and productive lives. The author has recently been referred a 15-year-old girl known to have cystic fibrosis from age three months and who had won the President's Award for physical fitness the previous year. Her main problem was nasal polyposis which is a frequent complication of cystic fibrosis in the older age group.

Nasal Polyps: Mucoid polyps in the nasal cavities are seen rather frequently in older children and adults with cystic fibrosis, and the presence

of such polyps constitutes an indication for sweat testing.[17] It would appear that polyps are most frequently seen in those patients whose cystic fibrosis is less severe than the average. The polyps may occur anywhere in the nasal cavity and occasionally in paranasal sinuses. They cause obstruction of the nasal passages, and if left untreated may lead to deformity of the nose. Polyps should be removed if symptoms justify surgery, but the recurrence is quite high.

Paranasal sinusitis is an invariable feature of cystic fibrosis. Clouding of all sinuses on X-ray is the rule. Agenesis of frontal sinuses and poor sinus development are frequently seen.

Other Problems: Apart from the many frustrations confronting the physicians and families of patients with cystic fibrosis related to the patient's pancreatic, hepatic, and respiratory problems, a whole host of new challenges are arising related to the changing age group of these patients. Prominent among these are the psychological problems resulting from the awareness of a short life expectancy and the knowledge of almost universal sterility in the male,[18] as well as the marked reduction of fertility in the female.[19] The older patients also tend to voice several rather consistent complaints including the cost of their medical care, their inability to obtain any form of insurance, their inability to gain weight and the great reluctance of their parents to allow them to lead independent, unsupervised lives.

Summary

A brief review of the clinical manifestations of cystic fibrosis is presented with illustrative case presentations. It is emphasized that the sweat test is the only consistent diagnostic tool at the physician's disposal. The indications for sweat testing are discussed from a clinical point of view. ◄

References

A complete bibliography for "Clinical Variations of Cystic Fibrosis" may be obtained by writing to: *Illinois Medical Journal,* 360 N. Michigan Ave., Chicago 60601.

▲ **Milwaukee Psychiatric Hospital** { Intensive, dynamic psychotherapy for adults and adolescents, individually planned activity therapy.

▲ **Milwaukee Sanitarium** { Geriatric program of superior care . . . custodial services for persons with chronic emotional illness.

▲ **Dewey Center** { Acute detoxification and inpatient treatment for alcoholic dependency, daily schedules, broad supportive services.

Units of: MILWAUKEE SANITARIUM FOUNDATION
1220 DEWEY AVENUE • WAUWATOSA, WIS. 53213 • PHONE (414) 258-2600

Affiliated with Medical College of Wisconsin
Accredited by the Joint Commission on Accreditation of Hospitals
Non-Profit Non-Sectarian Est. 1884 Participating Member Blue Cross-Blue Shield



Neuromuscular Dysfunctions of the External Urinary Sphincter

By Nader Sadoughi, M.D. and Irving M. Bush, M.D./Chicago

The significance of neurogenic bladder and detrusor-sphincter dyssynergia in paraplegic and quadriplegic patients with reflex type of neurogenic bladder has been well pointed out by Emmett, Cardus, Scott, Abramson, and others in the past.[1-6] However, in practice, little attention is paid to the dysfunctions of the external urinary sphincter as a cause for urinary tract infection and urinary stasis leading to significant deterioration of the upper urinary tract. Frequently, these disorders are misdiagnosed and mismanaged under the term of "neurogenic bladder."

The purpose of this paper is to present a new classification of dysfunctions of the external urinary sphincter based on our clinical and diagnostic data. We feel that this new classification will enable one to make the distinction between various dysfunction with greater accuracy, thereby directly aiding in the specific management of the patient.

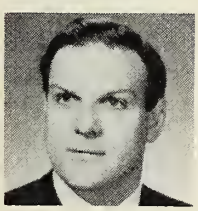
Method and Material

Sixty-five patients with known or suspected neuromuscular dysfunction of the lower urinary tract have been studied. Patient ages ranged from three and one half to 75. There were 50 males and 15 females. Prior to our study, a history, physical examination, blood urea nitrogen, serum creatinine, intravenous pyelography, urine culture and sensitivity, cystometry, cystoscopy and whatever medical studies seemed indicated by the patient's general condition, were carried out. Intravesical pressure measurements and direct cystometry, flowrate (instantaneous) and electromyography of striated external urinary sphincter were simultaneously measured and recorded according to the method of Cardus, Scott, Whitaker and Johnston.[5-8] Sphincterometry was also performed as described by Currie, Bunts, et al.[9] The urethral resistance (R) was then calculated by employing the following formula:[8]

$$R = \frac{\text{intravesical pressure}}{\text{flowrate}^2}$$



NADER SADOUGHI, M.D., is Head af the Divisian of Urology at Mount Sinai Medical Center and is an Associate Professor of Urology at the Chicaga Medical School University af Health Sciences. Dr. Sadaughi served a residency in urology at New York Medical College Haspitals. He is certified by the American Board of Uralogy and is a consultont in urology at Schwab Rehabilitatian Hospital, Chicoga.



IRVING M. BUSH, M.D., is Chairman and Attending Urologist, Chairman, Divisians of Urology at Cook County Hospital Hektoen Institute for Medical Research and Maunt Sinai Haspital Medical Center, Chicogo. He is Clinicol Professar and Chairman of the Division of Uralogy at The Chicogo Medical School and Prafessor, and Chairman, Deportment of Urology at Cook County Graduate Schaol af Medicine. Dr. Bush is the author af aver 50 clinical articles; 123 scientific papers; and 10 movies. He has invented numerous procedures and toals in the field of urology. He received his medical degree from the Chicaga Medical Schaal ond served a residency in urolagy at Beth Israel Hospital, New York.

Results and Classification

Based on an analysis of our studies of the lower urinary tract, three main clinical categories of the neuromuscular dysfunction of the external urinary sphincter were recognized: 1) hyperactive external urinary sphincter; 2) paralytic external urinary sphincter; and 3) asynchronous external urinary sphincter (Detrusor-sphincter dyssynergia).

1. Hyperactive External Urinary Sphincter

Among conditions most commonly encountered causing this dysfunction were: a) trauma to the spinal cord, b) myelomeningocele, c) multiple sclerosis, d) cerebrovascular accidents and e) advanced arteriosclerosis. The characteristics of hyperactive external urinary sphincter are summarized in Table 1.

Table 1.

CHARACTERISTICS OF HYPERACTIVE EXTERNAL URINARY SPHINCTER

1.	Urinary incontinence	=	Usually not present
2.	Voiding pattern	=	Frequency, urgency, nocturia and occasionally enuresis
3.	Motor Power	=	Normal
4.	Bulbocavernosus Reflex	=	Normal or hyperactive
5.	Bladder capacity	=	Normal or reduced
6.	Residual urine	=	Normal or elevated
7.	Intravesical pressure	=	Increases
8.	Sphincter pressure	=	Elevated
9.	Electromyography of the sphincter	=	Hyperactive with intermittent bursts of activity, but synchronous
10.	Urethral resistance	=	Normal or high

2. Paralytic External Urinary Sphincter

Paralytic external urinary sphincter may, also, be known as "flaccid urinary sphincter." In our experience, this dysfunction was seen following: a) cauda equina lesions, b) neoplasms of pelvic nerves, c) myelodysplasias, and d) pudendal anesthesia. Characteristics of paralytic external urinary sphincter are summarized in Table 2.

Table 2.

CHARACTERISTICS OF PARALYTIC EXTERNAL URINARY SPHINCTER

1.	Urinary incontinence	=	Stress incontinence
2.	Voiding pattern	=	Variable
3.	Motor Power	=	Impaired or absent
4.	Bulbocavernosus Reflex	=	Impaired or absent
5.	Bladder capacity	=	Usually normal
6.	Residual urine	=	Usually normal, but may vary
7.	Intravesical pressure	=	Normal or low
8.	Sphincter pressure	=	Reduced
9.	Electromyography of the sphincter	=	Fibrillation potentials, reduced activity or silence throughout with no voluntary activity.
10.	Urethral resistance	=	Usually low

3. Asynchronous External Urinary Sphincter

The most written about and the best known of the three dysfunctions is asynchronous external urinary sphincter.

Among the causes of this condition were: a) transection or crushing of the spinal cord above the conus medullaris, b) neoplasms of the spinal cord above the conus medullaris, c) myelomeningocele, d) multiple sclerosis, e) syringomyelia, f) extensive brain tumors or trauma, g) muscular dystrophy and h) electrical bladder stimulation. This type of dysfunction is usually associated with reflex type of neurogenic bladder and its characteristics are summarized in Table 3.

Table 3.

CHARACTERISTICS OF ASYNCHRONOUS EXTERNAL URINARY SPHINCTER

1.	Urinary incontinence	=	Usually present
2.	Voiding pattern	=	Frequent, interrupted, usually involuntary and precipitous
3.	Motor power	=	Normal
4.	Bulbocavernosus Reflex	=	Hyperactive
5.	Bladder capacity	=	Usually reduced
6.	Residual urine	=	Elevated
7.	Intravesical Pressure	=	Increased and hypertonic
8.	Sphincter pressure	=	Elevated
9.	Electromyography of the sphincter	=	Spastic, asynchronous contractions specifically during voiding
10.	Urethral resistance	=	High

Case Report

A 58-year-old male was admitted with acute urinary retention. Past history disclosed a back injury three years prior to his admission. On physical examination, the patient was found to be a well developed, well nourished male with slightly distended lower abdomen and diminished sensation as well as decreased motor power in his lower extremities. However, the rectal sphincter tone was normal and the bulbo-cavernosus reflex was present.

Laboratory studies revealed a normal blood count, chest X-ray and serology. Urine analysis revealed 20-30 W.B.C. per high powered field. The urine culture grew pseudomonas aerogenosa with colony count of over 100,000/ml. and was sensitive to Gentamycin.

An intravenous pyelogram revealed a normal upper urinary tract with a trabeculated bladder; a voiding cysto-urethrogram showed marked trabeculation of the bladder with a dilated posterior urethra, obstructed and markedly narrowed in the area of the external sphincter. (Fig. 1).



Fig. 1. Pre-operative voiding cystourethrogram. Note marked narrowing in the area of external urinary sphincter.



Fig. 2. Voiding cystourethrogram, three months following external sphincterotomy.

Pressure studies revealed elevated intravesical pressure with sphincteric pressure of 45 mm. of mercury (Hg.) Urethral resistance was found to be abnormally high and electromyography of the external sphincter showed marked hyperactivity of the external urinary sphincter with intermittent bursts of activity. It was concluded that the patient had a hyperactive (spastic) sphincter and he underwent an external sphincterotomy, according to the Bunts and Currie technique.[9] The catheter was removed three days post-operatively and the patient was able to void with no residual urine. The patient's urinary infection was treated with Gentamycin and he was discharged without a catheter.

Three months post-operative cysto-urethrogram, showed complete emptying of the bladder relieving the sphincteric spasticity with a wide stream (Fig. 2). Post-operative sphincterometry, also, showed a decrease of 25 m.m. of Hg. in sphincteric pressure and reduced urethral resistance.

On six months, and one year follow ups the patient was found to be free of urinary difficulties, he was voiding with good stream and has remained asymptomatic.

Discussion

Detrusor-sphincter dyssynergia is a dysfunction where the pelvic floor muscles do not reciprocally relax during voiding as in the normal individual, thereby preventing normal voiding in patients with reflex neurogenic bladders. We refer to this condition as asynchronous sphincter for greater clarity in contrast to the hyperactive dysfunction of the external urinary sphincter where, despite its spasticity, the sphincteric activity is synchronous and eventually relaxes during voiding to some degree. Asynchronous sphincters were encountered more frequently than the other two types of dysfunctions. Although significant number of cases with reflex neurogenic bladder were accompanied by asynchronous sphincters, other types of dysfunctions are not uncommon in daily urologic practice. All three conditions are often overlooked and cause significant urologic disabilities. Accurate differentiation of the external urinary sphincteric dysfunctions allows for the institution of appropriate early therapy and prevents complications.

Pressure studies may be successfully utilized as diagnostic tools notwithstanding criticism by some investigators regarding their lack of precision.[10]

Our experience has shown that electromyography and pressure studies have definite practical significance in the diagnosis and management of patients with neuromuscular dysfunc-

(Continued on page 514)

Electrical Alternans

Case Report and Comments on its Mechanism and Diagnostic Significance

By Sudarshan Kumar, M.B., M.R.C.P., F.R.C.P.C. and M. K. Dayhem, M.D., Ph.D./Chicago

While most of the clinical signs of uremia improved by hemodialysis, the response of pericardial tamponade to this treatment is variable. Bailey[1] stressed the value of dialysis in clearing even massive pericardial effusion whereas others[2-5] have reported several instances of cardiac tamponade that developed only after starting hemodialysis.

The difficulty in diagnosing tamponade clinically is well known.[6] This difficulty is especially pronounced in uremic patients because increased blood volume and the common incidence of congestive failure may simulate many of the clinical features of pericardial tamponade. Several authors[1,2] have noted that, in most patients, the electrocardiogram is of little help in diagnosing uremic pericarditis and tamponade.

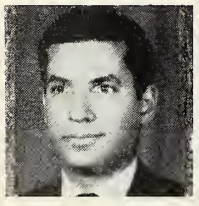
The purpose of this presentation is to describe the course of a patient who developed pericardial tamponade after hemodialysis and to stress the value of detecting electric alternans for the diagnosis and management of this complication.

Case Report

A 42-year-old male was admitted to the Mount Sinai Hospital complaining of gradually increasing right-sided chest pain of six days duration. The pain was accentuated by respiration and was associated with dry cough and dyspnea. He had suffered from chronic renal failure and systemic hypertension for the last four years and had been adequately maintained on bi-weekly hemodialysis since 1968.



SUDARSHAN KUMAR, M.B., M.R.C.P., F.R.C.P.C., is Director of the Catheterization Laboratory, Veterans Administration Research Hospital, Chicago, and Assistant Professor of Medicine, Northwestern University Medical School. Dr. Kumar is a graduate of King Georges Medical School at Lucknow University, India; Royal College of Physicians, Edinburgh; and Royal College of Physicians, Canada. He did fellowship training in cardiology at Tufts and Harvard Medical Schools, Boston.



M. K. A. DAYEM, M.D., Ph.D., is a faculty member of the Department of Medicine at Ein Shams University, Cairo Egypt. He is a graduate of the University of Cairo Medical School, Egypt and the Royal College of Physicians, Edinburgh and London. Dr. Dayem did advanced study at the Chicago Medical School.

On physical examination, the pulse was 100/min., without being paradoxus. The blood pressure was 120/80, the temperature was 99°F. There was a slight infection at the site of the arteriovenous fistula which had been created in his right arm for hemodialysis. The jugular veins were distended but Kussmaul's sign was not present. The cardiac apex was in the 5th intercostal space at the midclavicular line and there was one fingerbreadth dullness outside the apex. The heart sounds were normal. No pericardial friction rub or murmur was audible. Pleural rubs were heard on both sides of the chest. Chest X-ray revealed an enlarged heart and the electrocardiogram revealed evidence of left ventricular hypertrophy. Hemodialysis utilizing reginal antiocoagulation was performed on the second hospital day. There was transient improvement during the subsequent 24 hours, followed by progressive increase in jugular venous pressure and development of positive Kussmaul's sign and pulsus paradoxus. Repeated chest X-ray showed progressive increase in the cardiac silhouette, suggesting a rapidly accumulating pericardial effusion. Electric alternans was noted on the cardiogram but without overall diminution of the amplitude of the QRS complexes (Fig. 1). Pericardiocenthesis was performed through a 16 gauge percutaneous catheter and 500 ml of bloody pericardial fluid were removed.

Alternans was markedly diminished after removal of 250 ml and disappeared completely when 500 ml was aspirated (Fig. 2). The procedure was followed by decrease in the jugular venous distention and disappearance of both

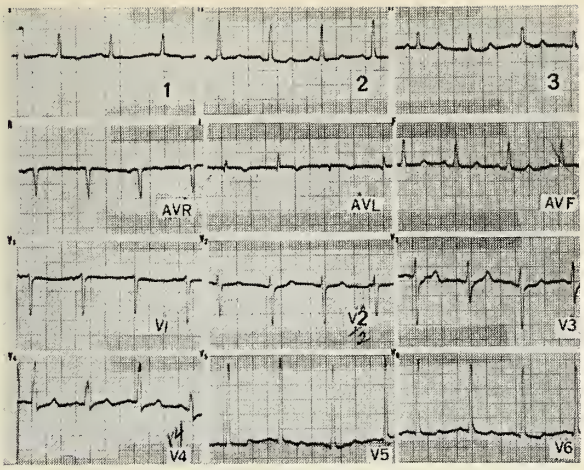


Figure 1. Electrocardiogram recorded immediately before pericardiocenthesis showing left centricular hypertrophy and "strain". Alternans is apparent in leads III, AVL, and V2 through V5. Note increased voltage of QRS complexes.

Kussmaul's sign and pulses paradoxus. The catheter was left *in situ* for continuous drainage of accumulating fluid. However, three hours later, the catheter became obstructed and was subsequently removed. Follow-up showed slow increase in jugular venous distention but no clinical signs of tamponade. Shortly afterward the patient developed an attack of ventricular tachycardia and was given 50 mg lidocaine intravenously. He then developed a slow idioventricular rhythm followed by cardiac arrest. All resuscitative measures were unsuccessful and the patient expired. Autospy showed a dilated heart with flabby myocardium and 400 ml of hemorrhagic fluid in the pericardial cavity.

Discussion

The occurrence of pericardial tamponade in uremic patients undergoing dialysis was first described by Kelemen and Kolff[7] in 1960. Bailey[1] later reported 10 patients who developed pericarditis while maintained on adequate dialysis. In all these cases, recent metabolic stress such as surgery or infection seemed to preceed the onset of pericarditis. In view of the fact that our patient had symptoms of pleuritic involvement at the beginning of his illness, it is possible that infection played a role in the evolution of pericarditis. The source of infection was not clearly determined although minor sepsis of the shunt site could have been responsible. The blood cultures were, however, sterile and no organisms were grown from pericardial fluid.

The exact mechanism of this complication is not clearly defined, osmotic imbalance of the dialysate and/or general body heparinization have been considered important contributory factors.

Regardless of the mechanism, prompt recognition and treatment of tamponade in these often critical patients is extremely important. The usual clinical signs of tamponade may be overshadowed by congestive heart failure. The electrocardiographic changes like low voltage of QRS complexes, and T wave abnormalities are similarly nondiagnostic. Although electric alternans of the QRS complexes is not pathognomonic of tamponade, its occurrence should alert the clinician to this possibility when a uremic patient appears to be slipping into circulatory congestion and collapse. In our patient, electric alternans provided a sensitive and reliable criterion of increased intrapericardial pressure and promptly disappeared after partial pericardiocentesis: its reappearance again strongly suggested the reaccumulation of critical pericardial fluid (Fig. 2). Therefore, it proved useful in assessing the response to pericardiocentesis.

The exact mechanism for the production of electric alternans is not known. Two possibilities have been considered:[8] changes in the position of the heart with alternating beats and conduction aberration. Angiocardiographic studies have demonstrated rotating oscillations of the heart[9]

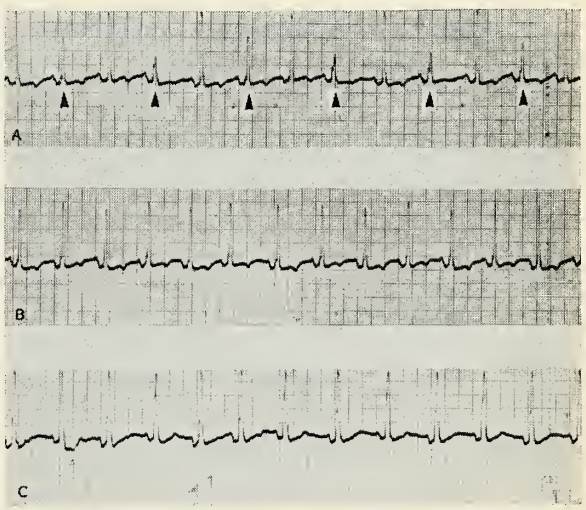


Figure 2. Three continuous strips of a monitor lead.

A. Before pericardiocenthesis, showing 2:1 alternans.

B. After removal of 250 ml of pericardial fluid showing minimal alternans.

C. After removal of 500 ml of pericardial fluid showing no alternans.

There is no change in the voltage of the QRS complexes.

and echocardiography has shown an anterior position shift with one beat, and a posterior position shift with another beat.[10,11] A significant shift in the maximum QRS vector in the frontal and horizontal planes has also been reported in the alternating complexes.[11]

Its recent demonstration in excised perfused rabbit heart suspended in a fluid filled spherical chamber lends more weight to mechanistic hypothesis based on anatomic rotation of the heart.[12]

In clinical setting electric alternans has been found in rapidly progressing tamponade of malignant, uremic, infective, traumatic and tuberculous origin. It also has been recorded in tamponade in subacute effusive constriction.[13] Etiology of tamponade therefore does not seem to be of significant importance, although it has not been documented in post-dialysis cases to our knowledge. A critical rise in the intrapericardial pressure seems to be one of the most important determining factors in its production.[8] It is unrelated to and should not be confused with *pulsus alternans* which is characterized by alternating amplitude of peripheral arteries.

Alternating intensity of the heart sounds, of the amplitude of peripheral arteries and electric alternans have been occasionally described in the same patient.[11, 14]

Summary

A 42-year-old man with chronic renal failure, maintained on adequate dialysis, was admitted with chest pain. He was found to have pericarditis with effusion. After successful dialysis, he experienced cardiac tamponade. Electric alternans of the QRS complexes was found to be a useful sign for diagnosing and following the course of tamponade. After partial aspiration, this sign disappeared but returned with critical reaccumulation of fluid. The diagnosis of pericardial effusion and tamponade in uremic patients can be difficult because of frequent fluid retention and heart failure. It is suggested that the presence of electric alternans should raise the possibility of tamponade in these circumstances. ◄

References

1. Bailey, G. L., Hampers, C. L., Hager, E. B., and Merril, J. P.: "Uremic Pericarditis." *Circulation,* 38: 582-591, 1968.
2. Beaudry, C., Nakamato, S., and Kolff, W. J.: "Uremic Pericarditis and Cardiac Tamponade." Report of Four Cases. *Ann. Int. Med.,* 64:990-995, 1966.
3. Seymon, H. S. and Wrong, D. M.: "Uremic Pericarditis with Cardiac Tamponade. Report of Four Cases." *Brit. Med. J.,* 1:605-606, 1964.
4. Hager, E. B.: "Clinical Observation on Five Patients with Uremic Pericardial Tamponade." *N. Eng. J. Med.,* 273:304-308, 1965.
5. Schupak, E., and Merrill, J. P.: "Experience with Long-Term Intermittent Hemodialysis." *Ann. Int. Med.,* 62:509-518, 1965.
6. Williams, C., and Soutter, L.: "Pericardial Tamponade. Diagnosis and Treatment." *AMA Arch. Int. Med.* 94:571-584, 1954.
7. Kelemen, W. A. and Kolff, W. J.: "Evaluation of Dialysis in Treatment of Chronic Renal Failure. Study of Twenty-Eight Cases Treated in One Year." *AMA Arch. Int. Med.,* 106:608-618, 1960.
8. Spodick, D. H.: Electrical Alteration of the Heart. Its Relation to the Kinetics and Physiology of the Heart During Cardiac Tamponade. *Am. J. Cardiol.,* 10:155-165, 1962.
9. Price, E. C. and Dennis, E. W.: "Electrical Alternans, Its Mechanism Demonstrated." *Circulation,* 40:Supplement III, 165, 1969.
10. Feigenbaum, H., Zaky, A., and Grabhorn, L. L.: "Cardiac Motion in Patients with Pericardial Effusion." *Circulation,* 34:611-619, 1966.
11. Gabor, G. E., Wisberg, F., and Bloam, H. S.: "Electrical and Mechanical Alteration in Pericardial Effusion." *Chest,* 59:341-344, 1971.
12. Brody, D. A., Copeland, G. A., Cox, J. W., Keller, F. W., Wennemark, J. R., and Warr, O. S.: "Experimental and Clinical Aspects of Total Electrocardiographic Alternation." *Amer. J. Cardiol.* 31:254-259, 1973.
13. Spodick, D. H. and Kumar, S.: "Subacute Constrictive Pericarditis with Tamponade." *Dis. Chest,* 54:62-66, 1968.
14. McGregor, M. and Baskind, E.: "Electrical Alternans in Pericardial Effusion." *Circulation* 11:837-843, 1955.

Love of Man

Sometimes give your services for nothing, calling to mind a previous benefaction or present satisfaction. And if there be an opportunity of serving one who is a stranger in financial straits, give full assistance to all such. For where there is love of man, there also is love of the art. For some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician. And it is well to superintend the sick to make them well, to care for the healthy to keep them well, but also to care for one's self, so as to observe what is seemly. —Hippocrates Precepts. Chap. 6

Treating Psoriasis of The Scalp With A New Corticosteroid Lotion

By Roland S. Medansky, M.D. and Raymond M. Handler, M.D./Park Ridge

The only thing pleasant about the silvery scales of psoriasis is in its descriptive name. Reportedly an estimated 1 to 5% of the population at large are affected with this disease. Although most patients recognize the fact that, as yet, there is no known cure for their condition, all they ask is what the physician can do for their psoriasis now. Preparations for the treatment of psoriasis run the gamut of tars, ammoniated mercury, anthralin, corticosteroids and methotrexate.

As Stoughton[1] recently stated at an International Symposium on Psoriasis, "Only a few drugs have proven to be able to cause the lesions of psoriasis to disappear. Among these are the glucocorticosteroids, which can work either by systemic or topical administration. It is curious that after 20 years of use, we do not know the way in which glucocorticosteroids effect the resolution of psoriatic lesions. However, this goes along quite well with the fact that after 5000 years we have no idea of the molecular basis for the psoriatic lesion."

Clinically, psoriatic signs are easily identifiable. The erythematous papules and plaques (often red-brown) with dry thick adherent silvery scales are rounded and well demarcated. Psoriasis tends to be symmetrical and is usually found in the scalp, elbows, knees and sacral sites. In the scalp, particularly, the scales may cover the entire area. It may extend along the hairline, forehead or behind the ears. In the nails and intertriginous areas, its morphology is apparently different.



ROLAND S. MEDANSKY, M.D., is Clinical Associate Professor in Dermotology at the University of Illinois College of Medicine.



RAYMOND M. HANDLER, M.D., is Clinical Assistant Prafessor in Dermatology at the University of Illinois College of Medicine.

Drs. Medansky ond Handler are on staff at Luthern Generol Hospital, Park Ridge and Resurrection Hospital, Chicago and maintain o private practice in Park Ridge.

In a preliminary study of a rigidly controlled double-blind study of a new corticosteroid formulation (betamethasone valerate* vs. its vehicle) as a 0.1% lotion, the published results[2] on seborrheic dermatitis and psoriasis of the scalp were sufficiently interesting for us to reexamine our original evaluation in scalp psoriasis; we extended our study and combined our results via the computer with those of 14 other investigators to determine whether or not the success rate in the more severe, difficult-to-treat psoriatics would be similar. This technique was possible since all the investigators,[3] although in different sectors of the country, followed a similar protocol and procedure.

Patient Selection, Study Design

All the study groups were made up of patients with psoriasis of the scalp. Patients selected were not to have had previous systemic or topical corticosteroid therapy or if they had, there was to be at least a one week interval after its discontinuance before study initiation. No other medications were to be used.

A randomized double-blind technique was used. One half the patients were to be treated with the active lotion and the other half with the placebo lotion. Each patient was assigned a sequential admission number corresponding to a treatment unit outlined on the accompanying randomization schedule.

Clinical observations were recorded initially, after three days, seven days, and 14 days according to the following criteria:

Excellent—Complete clinical control of condition (75% or more)
Good—Moderate control (50% to 75%)
Fair—Partial control (less than 50%)
Poor—No effect.

Valisone® (brand of betamethasone 17-valerate) Schering Corporation, Bloomfield, New Jersey.

Table 1

Parameter	Visit	Treatment Favored	p value
Physician Evaluation	**2**	**Beta. val.**	**p <.001**
	3	**Beta. val.**	**p <.001**
	4	**Beta. val.**	**p <.001**
Physician Overall Evaluation	**Final**	**Beta. val.**	**p <.001**
Patient Evaluation	**2**	**Beta. val.**	**p <.001**
	3	**Beta. val.**	**p <.001**
	4	**Beta. val.**	**p <.001**
Comparison to Standard	**Final**	**Beta. val.**	**p <.001**

Evaluation of results (safety and efficacy) was based on the above criteria plus a correlation of a patient questionnaire and observation of the changes in signs and symptoms.

Results

A total of 219 patients were treated. Of this total, six of the investigators evaluated 174 patients and the other nine evaluated 45 patients.

The physicians overall evaluation of therapy is as follows:

Psoriasis of the Scalp	Betamethasone valerate lotion	Placebo
Excellent	48 (41.0%)	8 (7.8%)
Good	19 (16.2%)	27 (26.5%)
Fair	29 (24.8%)	21 (20.6%)
Poor	21 (17.9%)	44 (43.1%)
Exacerbation	0	2 (2.0%)
	117	102

Statistical Analysis

Statistical analysis of the data was performed via the Wilcoxin two sample test. One tail tests were reported.

Analysis was performed on the following parameters:

1. physician evaluation of efficacy at each visit
2. physician evaluation of efficacy—overall evaluation
3. patient evaluation of efficacy at each patient visit
4. physician evaluation as compared to his standard therapy
5. physician evaluation of the following signs and symptoms at each patient visit
 (a) excoriation
 (b) inflammation
 (c) scaling
 (d) crusting
 (e) pruritus

In every instance where there was a statistical difference, active betamethasone valerate proved statistically superior to the vehicle. There were no instances of vehicle superiority. The probability value in both physician and patient evaluation was $p < .001$. (Table 1)

(Continued on page 516)

Table 2

Parameter	Vitit	Treatment Favored	p value
Excoriation	**2**	**Beta. val.**	**p = .003**
	3	**Beta. val.**	**p = .014**
Inflammation	**2**	**Beta. val.**	**p = .076**
	3	**Beta. val.**	**p = .002**
	4	**Beta. val.**	**p = .001**
Scaling	**2**	**Beta. val.**	**p = .022**
	3	**Beta. val.**	**p = .002**
	4	**Beta. val.**	**p = .002**
Crusting	**3**	**Beta. val.**	**p = .012**
	4	**Beta. val.**	**p = .003**
Pruritus	**2**	**Beta. val.**	**p = .019**
	3	**Beta. val.**	**p = .006**
	4	**Beta. val.**	**p = .006**

No other significant differences are indicated ($p > .10$)

Lithium Carbonate in the Treatment of Manic-Depressive Disorders: A Follow Up Study

By Patricia A. Mueller, M.D. and Edward A. Wolpert, M.D., Ph.D./Chicago

In 1966, a clinical study was begun to test the effectiveness of Lithium Carbonate as an agent in the treatment of manic depressive psychosis both in the acute manic phase, and when used chronically with manic depressive patients as a prophylactic agent to prevent recurrence of extreme affect swings.[1] This study differed from many previous clinical investigations[2-4] in that it was conducted within the setting of a psychiatric hospital treating private, service and research patients in a milieu in which emphasis on interpersonal and intrapsychic forces prevails. Patients were closely followed both in and out of the hospital by their own physicians so that the acute and maintenance dosages of the drug could be varied according to the patients' individual needs.

Originally only those manic depressive patients were included whose illness had been of at least two years duration and who had not responded to conventional treatment (drugs and electric shock treatment). Those patients diagnosed by their attending psychiatrist as suffering (at the time treatment began) from "manic depressive psychosis, hypomanic (or manic) phase" were studied. In June, 1969, FDA approval was given to expand the research to include both patients who had a clear history of manic-depressive psychosis for at least two years duration, but who at the time Lithium was begun were depressed and patients with recurrent depressive episodes for at least two years duration who experienced recurrence despite psychotherapy and/or chemotherapy, but who did not have hypomanic swings.

All patients referred for evaluation were screened to exclude those patients with significant renal, cardiac or neurologic disease. Those patients selected to be treated with Lithium were told of the experimental nature of the drug and its possible side effects. No attempt was made to conceal from the patients the anticipated therapeutic effects of the drug. Each patient was his own control.



PATRICIA A. MUELLER, M.D., is Assistant Director of Outpatient Clinic, Illinois State Psychiatric Institute, Chicago and maintains a private practice in psychiatry. A graduate of the University of Chicago School of Medicine, Dr. Mueller is currently in training at the Chicago Institute for Psychoanalysis.



EDWARD A. WOLPERT, M.D., Ph.D., is Director of Clinical Services, Psychosomatic and Psychiatric Institute of Michael Reese Hospital and Medical Center and Clinical Associate Professor of Psychiatry, University of Chicago, Pritzker School of Medicine. Dr. Wolpert is a Fellow, American Psychiatric Association, Certified in Psychiatry, American Boards of Neurology and Psychiatry, Inc. He is a graduate from the Chicago Institute for Psychoanalysis.

Methodology

Patients were initially given 300 mgm of Lithium Carbonate four times a day until the blood level was in the range of 0.4 to 0.6 meq/ml. If no response had by then occurred, the dosage was raised until a response occurred or until the blood Lithium level reached a maximum of 1.4 meq/ml. The range of Lithium used to obtain a response varied from 600 to 2,700 mgm/day (See table). When a therapeutic response—resolution of the mania, or lifting of the depression—was observed, the dose of Lithium was decreased until a maintenance dosage assuring a blood level in the range of 0.4 to 0.6 meq/ml was obtained. The range of maintenance Lithium was from 600 to 1,800 mgm/day. Patients on Lithium were also given one gram NaCl/day for each 300 mgm of Lithium they were taking to an upper limit of 4 grams NaCl/daily. (More than 4 grams of Sodium Chloride daily was found to cause a metabolic alkalosis in some patients). After 1969, Sodium Chloride was omitted.

Blood Lithium levels were obtained initially every four days until a maintenance level was reached. After stable blood Lithium levels were observed weekly for 2-4 weeks, blood Lithium levels were obtained at least monthly for three months, then every two months until levels were felt to be quite stable.

The behavior of the patients was observed both in therapy sessions with their attending

psychiatrist and by the nurses in the hospital and a day to day record was kept of the patient's mood. Patients were discharged when the manic or depressed state had been resolved and the patient stabilized on maintenance levels of the drug. Follow-up has consisted of physicians answering questionnaires designed to elicit information concerning the vicissitudes of outpatient treatment. Among the critical questions were: did the patient have subsequent manic or depressive episodes and if so how were they treated?; did the chemotherapy effect psychothrapy in any particular way?; did the chemotherapy effect the patient's life style?; and what problems did the physician have in using the drug?

Results and Discussion

The patients in this study have been divided into five categories to simplify the interpretation of the results (See table).

1. Manic Depressive Psychosis, Manic Phase:

Patients who were diagnosed as having manic depressive psychosis and who were first treated with Lithium during the manic phase have shown the best response to Lithium, both during the acute manic episode and when Lithium is used as a maintenance drug. Of the 14 patients in this category, 13 responded well to Lithium Carbonate during the acute manic episode and of these patients 11 are still taking Lithium. Only one of the patients taking Lithium as a maintenance drug (Case 9) has had a recurrence of a mood swing severe enough to require hospitalization and other medication, but even in this case one depressive episode in almost two years represents a significant improvement over the two to four episodes per year she experienced previously. In addition, while pre-Lithium hospitalization required three months for resolution of the mood swing, the post Lithium hospitalization lasted only one month.

Side effects were generally absent on maintenance dosage with the exception of the one patient in this group (Case 25) whose affective state was unaffected by Lithium Carbonate. She developed lethargy and gastro-intestinal symptoms on 1200 mgm daily and was later found to be hypothyroid.

Minor mood variations (either slight depression or slight hypomania) continued in seven of the 11 patients taking maintenance Lithium but were effectively treated by a temporary increase in the patients' Lithium intake. These mood swings gradually become less frequent. Eleven of these patients experienced definite improvement in their work, their family life or in their relationships to friends. The improvements are generally described in terms of the patient becoming "more reliable," "more stable," "more productive."

Many of these patients on Lithium maintenance reported no noticeable change in the way they felt generally, but some made comments such as "I've lost what used to be a friendly feeling of being excited. Now if it returns it's not friendly," or "I don't feel as strongly as before." Some simply felt "curbed." One successful Lithium treated patient remarked that she felt she "had less energy." In most instances successful maintenance therapy with Lithium made no difference in psychotherapy, which generally had been superficial both before and after Lithium treatment. There were occasional reports of psychotherapy becoming more meaningful and productive; these were balanced by other reports of therapy becoming more supportive, dealing with less emotional issues and becoming environmental counseling.

The results in this group (improvement of the acute manic state in 13 out of 14 patients—93%) are in general agreement with other studies[3] giving the improvement rate in the acute manic state treated with Lithium as from 60-100%.

The present study also confirms the reports of almost all previous observers that Lithium Carbonate is effective as a prophylactic agent in manic-depressive psychosis,[3,5-8] not only in reducing the frequency of manic or depressive mood swings severe enough to require hospitalization, but also in preventing the slight endogenous mood swings of sub-psychotic intensity which formerly had adversely affected the patient's relationships with family, friends and their functioning at work.

2. Manic Psychosis:

Lithium treatment was effective both acutely and prophylactically in the one patient (Case 4) included in the study who in the past had experienced only manic episodes.

3. Manic Depressive Psychosis, Depressed Phase:

Results were more varied in those five manic-depressive patients who were treated during the depressed phase of their illness. In three cases (3, 22, 27) Lithium has been effective both in treating the acute depressive phase and in prevention of recurrence (though in Cases 22 and 27 not enough time has elapsed to be sure that the effect is due to Lithium). It is notable that Lithium has been quite effective in Case 3 despite the presence of paranoid ideas during manic and depressed episodes. In Case 8 Lithium produced side effects bothersome enough to the

patient (who thought, possibly erroneously, that Lithium was interferring with his sex life) to warrant discontinuance of the drug, and was ineffective in controlling his mood swings. In view of this patient's having a history of only one mood swing (a depression) severe enough to require hospitalization, it is possible that the diagnosis of manic depressive psychosis was incorrect. It is as yet too soon to assess the prophylactic effect of Lithium in Case 31 who has only been taking the drug for one month. It is perhaps significant, however, that only those two patients in whom the drug was ineffective in aborting the acute depression had recurrences of severe symptoms while on maintenance Lithium.

4. Recurrent Depression:

In the present study Lithium Carbonate not only has had little effect on patients with recurrent depressions, but also more side effects were noted in this group of patients than in manic depressive patients taking the same daily amount of Lithium. However, in Case 28 Lithium has proved quite effective in lifting the acute depression and in combination with Tofranil® proving to be more effective in preventing recurrences than Tofranil® alone (which was tried prior to Lithium).

In the literature there is considerable question over whether Lithium Carbonate is effective in acute depressions. Initially, it was reported that in the "acute" treatment of a depressive illness or a depressive phase of manic depressive disease Lithium is without effect.[9-11] It has been reported to have weak anti-depressant properties compared to imipramine.[12] Some authors have reported improvement of depression with Lithium. Andreani[13] and associates stated that 10 of 24 cases improved and Vajtechavsky[14] reported improvement in 8 of 14. Dyson and Mendels[15] reported that Lithium had no effect in 9 cases of neurotic depression and 3 cases of involutional depression but that most of the 19 cases of manic-depressive illness in a depressed phase responded to Lithium in one week. Schou[4] noted that though many investigators feel that Lithium has no value in severe depression, if it is given prophylactically to patients still moderately depressed, it is a frequent observation that the depression comes to an end earlier than would be expected to happen spontaneously.

5. Other Psychoses:

Included in the study were five patients who were initially felt to be manic depressive, but who subsequently exhibited an overt thought disorder. Lithium Carbonate had no effect on four of these patients. In Case 12, Lithium was effective in treating what appeared to be an acute manic episode, but was ineffective in preventing or treating a later "schizo-affective" episode (however, blood Lithium levels as an outpatient were quite low, casting doubt on whether she took the drug responsibly). In Case 30, Lithium failed to prevent recurrent psychotic (paranoid schizophrenic) episodes, the patient did seem less depressed with longer intervals between psychotic episodes. This could have been due to a placebo effect rather than the drug itself.

In contrast, Lithium Carbonate was effective in both the acute and chronic treatment of Case 3 who exhibited paranoid ideation along with extreme affect swings. Evidently the paranoid ideas were not sufficiently prominent to cause the patient's physician to revise his original diagnosis of manic depression psychosis.

In a review of the literature Schou[4] stated that patients do less well on Lithium when the manic picture is tainted with atypical features such as delusions without overt relationship to mood, hallucinations of more than episodic character, periods with reticence and contact difficulties, or gross hysterical symptoms. In one clinical study Fries[16] reported that 90% of typical manics responded to Lithium, but only 54% of atypical cases. He concluded that Lithium may ameliorate the affective overlay in schizophrenia, but that it is unlikely that Lithium has any specific effect on the schizophrenic process itself. Lithium had no clear or lasting effect on the six atypical cases included within the present study. The results in the present study are in agreement with these findings that Lithium has no effect on schizophrenia itself but may (as in Case 30) decrease the affective overlay in some patients.

Hazards Encountered in the Use of Lithium Carbonate

Two main groups of side effects have been described.[3,4] One group of undesirable effects is associated with relatively low serum Lithium levels and represents an inconvenience rather than a danger. These effects often coincide with serum Lithium peaks and the effect may be related more to the steepness of the rise of Lithium levels than to the height of the peak. Symptoms included within this group are anorexia, transient gastric discomfort, vomiting, diarrhea, thirst, polyuria, tiredness and a hand tremor which does not respond to anti-parkinson medication. Often these symptoms disappear or di-

PATIENTS WITH MANIC DEPRESSIVE PSYCHOSIS TREATED WITH LITHIUM DURING DEPRESSED PHASE

Case No.	Age	Sex	Frequency of Extreme Swings Prior To Lithium	Effect of Li. On Acute Episode	Max. Dose	Length on Lithium	Maintenance Dosage	Recurrence of Mood Swings While On Maintenance Lithium: Mild	Extreme	Treatment of Recurrence	Effect	Side Effects of Lithium	Other Drugs Used With Lithium	Patients Still Taking Lithium
3	56	M	2-4/year for 20 yrs. + paranoid ideas	+	900 mgm	3 yrs. 1 mo.	1200mgm/d	+	—	Lithium	+	—	—	YES
8	45	M	One severe depression requiring hospitalization in 23 yrs of illness	—	1200 mgm	D/C after 5 months		+	+ M & D	Supportive Psychotherapy	+	Diarrhea, weakness	—	NO pt. stopped because of side effects
22	62	F	2 manic episodes/5 yrs. 1 depression/2 yrs.	+	1200 mgm	10 months	1200mgm/d	—	—	—		—	—	YES
27	41	F	2 per year for 5 yrs.	+	1800 mgm	4 months	1200mgm/d	—	—	—		Rash	—	YES
31	29	M	2 per year for 2 yrs.	—	1200 mgm	1 month	1200mgm/d	+	+ Depression	Hospitalization	+	—	—	YES
PATIENTS WHO HAVE ONLY RECURRENT MANIC EPISODES—NO DEPRESSIONS														
4	29	F	Once/2 yrs. for 6 yrs.	+	1200 mgm	2 yrs. 8 mo.	900 mgm/d	—	—	—		—	—	YES
PATIENTS WHO HAVE ONLY RECURRENT DEPRESSIONS														
21	28	M	Chronic depression for 7 yrs.	—	1500 mgm	Li D/C'd while pt. Hosp. as no effect	Lithium Not Continued for Maintenance					Nausea	Depression unaffected by Lithium plus anti-depressants used	NO
23	58	F	2 depression/year for 7 yrs.	—	1200 mgm	Li D/C'd after 2 mo. because of side effects	900 mgm/d in hospital Lithium Not Continued for Maintenance					Hand Tremors	After Lithium D/C'd as no affect Vivactyl and EST cleared depression	NO
26	62	M	3-4/year for 7 yrs.	—	1200 mgm	7 months	1200 mgm	+	+ 3 times	One hospitalization, EST antidepressant		Nausea, Tremor	Vivactyl also	YES
28	46	F	20/year for 7 yrs.	+	1200 mgm	4 months	900 mgm/d	+	—	Supportive Rx		On 1200 mgm/d Nausea, Severe Tremors	Patient also being treated with Tofanil	YES
29	30	F	3-4/year for 5 yrs.	—	2400 mgm	Li D/C'd after 2 mos.	1200-2400 mgm/d D/C'd	Not Continued for Maintenance				On 2200 mgm Fine Tremor Abdominal pain	Patient also treated with Librium	NO

PATIENTS WITH MANIC-DEPRESSIVE PSYCHOSIS TREATED WITH LITHIUM DURING MANIC PHASE

Outcome of Lithium Treatmentas of June, 1970

Case No.	Age	Sex	Frequency of Extreme Mood Swings Prior To Lithium	Effect of Li. On Acute Episode	Daily Max. Dosage Used For Acute Episode	Length On Lithium	Maintenance Dosage	Recurrence Of Mood Swings While On Maintenance Lithium: Mild	Recurrence Of Mood Swings While On Maintenance Lithium: Extreme	Treatment Of Recurrance	Effect	Side Effects Of Lithium	Other Drugs Used With Lithium	Patients Still Taking Lithium
1	45	F	6-8/years for 3 yrs.	+	1200 mgm	3 yrs. 9 mos.	600 mgm/d	+ M.-D.	—	LITHIUM	+	—	—	YES (Pt. stopped Li once, became manic and mania subsided when pt. continued with Lithium
2	47	F	2/year for 5 yrs.	+	900 mgm	3 yrs. 1 mo.	600-900 mgm/d	+ M.-D.	—	LITHIUM	+	—	—	YES
5	21	F	2/year for 7 yrs.	+	1200 mgm	1 yr.	900 mgm/d stopped 6/68	—	—	—		—	—	NO—pt. stopped as she was stable for 6 mos. no recurrence but somewhat cyclothymic since stopped
6	42	M	2-3/year for 14 yrs.	+	1200 mgm	2 yrs. 7 mos.	900-1200 mgm/d daily	+ M	—	LITHIUM	+	—	—	YES
7	46	M	6-8/year for 11 yrs.	+	2400-2700 mgm	2 yrs. 4 mos.	1200 mgm/d	+ M.-D.	—	LITHIUM	+	None on maintenance dose only on 1800 mgm/d or more ataxia; tremors	—	YES
9	60	F	2-4/year for 5 yrs.	+	900 mgm	1 yr. 11 mos.	1200 mgm/d	+ D	+ depression	Hospitalization & Elavil plus Lithium (1 month)	+	Tremors once-stopped when Lithium briefly stopped none later on Lithium	Elavil for severe depression Thorazine 25-50 mgm QID in initial manic phase	YES
10	47	M	4/year for 2 yrs.	+	2700 mgm	1 yr. 9 mos.	1800 mgm/d	+ M.-D.	—	LITHIUM	+	None on maintenance dose nausea, weakness, headaches on prolonged doses of 1800 mgm	—	YES
11	57	M	2/year for 2 yrs.	+	1200 mgm	2 yrs.—patient unreliable in taking Lithium		patient dropped from study not taking med.				—	—	NO
14	39	F	Manic Attacks 1-2/year for 4 yrs. 1 dep/3 yrs. for 20 yrs.	+	1200 mgm	1 yr. 4 mos.	1200 mgm/d	+ M.-D.	—	LITHIUM	+	—	—	YES
16	19	M	2/year for 2 yrs.	+	1800 mgm	1 yr. 2 mos.	1200-1800 mgm/d	—	—	—		RASH	—	YES
18	47	F	1/year for 3 yrs.	+	1800 mgm	11 mos.	900 mgm/d	—	—	—		On high doses nausea, drowsiness, urinary frequency hand tremor	—	YES
19	55	F	Total history of only one mania and one depression	+	1800 mgm	10 mos.	300-900 mgm/d	+ M	—	LITHIUM	+	—	—	YES
24	42	M	2/year for 10 yrs.	+	600 mgm/d	9 mos.	1500 mgm/d	—	—	—		—		YES
25	65	F	4-6/year for over 5 yrs.	—	2400 mgm	D/C'd after 2 months was on 1200 mgm daily		(pt not on maint. Li +)	+ depression	HOSPITALIZATION		Lethargy and GISx. hypothyroidism		NO—D/c because of symptoms & hypothyroidism

minish without reduction of dose, though some may persist such as thirst, polyuria, and tremor. Cutaneous conditions have also been described[17] which appeared during the first three weeks of treatment with Lithium and disappeared when the dose was reduced.

Toxic effects seen at blood levels above 1.5 meq/liter are more serious and include muscle fasciculation and twitching, hyperactive deep tendon reflexes, ataxia, somnolence, confusion, dysarthria and rarely epileptiform seizures. Such symptoms indicate severe Lithium intoxication and can progress to coma and death, if untreated. Electrocardiographic changes may occasionally occur. Such symptoms are rare if blood levels of Lithium are monitored and kept below 1.5 meq/liter.

A small number of cases of thyroid disturbance have been reported in patients on maintenance Lithium for periods from five months to two years.[3,4,18] In these cases slight to moderate enlargement of the thyroid gland, sometimes associated with cold nodules, occurred though most of the patients were euthyroid. A few patients however, exhibited hypothyroid symptoms. In some cases, withholding Lithium led to return to normal thyroid function. Treatment with thyroxin or dessicated thyroid led to diminution in size of enlarged glands despite continued treatment with Lithium.

In occasional cases,[3] either early or later in the course of Lithium therapy, an impairment in the ability to concentrate urine developed, unassociated with any other signs of Lithium toxicity (and at non-toxic blood Lithium levels). This concentration defect was refractory to pitression administration, indicating that no central impairment of antidiuretic function was involved.

Among the patients in the present study no major toxic effects were noted. Some patients, however, experienced minor side effects such as nausea, tremors, ataxia, diarrhea, weakness and occasional drowsiness on high initial doses of Lithium. These symptoms generally were not incapacitating for the manic depressive patients and subsided when the Lithium Carbonate dosage was reduced. Two patients developed a rash which was not severe enough to necessitate discontinuance of the drug and which also subsided when the Lithium was decreased. With the exception of Case 8 and 25 manic depressives experienced no side effects on maintenance doses of Lithium Carbonate.

Side effects were a much greater problem for patients diagnosed as recurrent depression and often led to the patient's discontinuing the drug. These side effects continued even when the patient was taking relatively small amounts of Lithium. This finding might indicate (as does the fact that Lithium has little therapeutic effect in these patients) that manic depressive psychosis and recurrent depression are distinct clinical entities and possibly that these patients' systems handle Lithium differently.

One patient in this study (Case 25) developed hypothyroidism after two months on Lithium. The disturbance developed somewhat earlier than has been so far reported in the literature. This is a serious potential complication of Lithium therapy and for this reason periodic thyroid function tests would be recommended for any patient taking Lithium.

Conclusions

On the basis of the present study Lithium Carbonate appears to be a very effective agent for the acute and chronic treatment of patients with well documented manic depressive psychosis.

The greater effectiveness of Lithium Carbonate in patients who were first treated during their acute manic phase than in manic depressives treated when depressed, may be due to the fact that a manic episode, when observed by the patient's attending physician, is more clearly diagnostic of manic depressive psychosis than an observed depression in a patient who gives a history of "manic episodes" which were not subject to direct observation.

Preliminary results in treating recurrent depressions with Lithium are disappointing.

In manic depressive psychotics on chronic Lithium treatment, side effects are negligible on maintenance dosage. Side effects seem to be more common in patients whose mood is unaffected by Lithium Carbonate. ◄

References

1. Wolpert, E. A., Mueller, P.: "Lithium Carbonate in the Treatment of Manic-Depressive Disorders." *Arch. Gen. Psych.*, 21:155-159, 1969.
2. Fieve, R. R., Gattozzi, A. A.: "Interdisciplinary Studies of Manic-Depressive Psychosis." Mental Health Program Reports 4, 1970.
3. Gershon, S.: "Lithium in Mania." *Clinical Pharmacology and Therapeutics*, 11:2, 168-187, 1970.
4. Schou, M.: "Special Review: Lithium in Psychiatric Therapy and Prophylaxis." *Journ. Psychiat Res.*, 6: 67-95, 1968.
5. Baastrup, P. C., Schou, M.: "Lithium as a Prophylactic Agent: Its Effect Against Recurrent Depressions and Manic-Depressive Psychosis." *Arch. Gen. Psych.*, 16:162-172, 1967.

PATIENTS ORIGINALLY DIAGNOSED AS MANIC DEPRESSIVE WHOSE PHYSICIANS SUBSEQUENTLY CHANGED THE DIAGNOSIS

Case No.	Age	Sex	Original Diagnosis	New Diagnosis	Effect Of Lithium On Acute Episode	Effect Of Lithium In Maintenance	Side Effects
12	44	F	Manic Depressive "Hi" when Rx'd	Schizo Affective Psychosis	Rapid calming effect 1st time no effect on later manic/schizophrenic episode for which she was hospitalized (maximum dose 1500 mgm)	None	0
13	34	M	Manic Depressive (equivocal)	Schizo Affective Psychosis	(maximum dosages 1800 mgm) None: Lithium D/c'd After 2 months	—	0
15	45	M	Manic Depressive? with paranoid ideas "Hi" when Rx'd	Schizo Affective Psychosis	None	Patient not followed	0
17	35	M	Recurrent Depression (?)	Unclear Picture Alcoholic	None Lithium D/c'd After 1 month	—	0
20	19	M	Manic Depressive "Hi" when Rx'd	Schizophrenia	+ ? —	Nothing definite no mood swings on Lithium but six months after Lithium stopped schizophrenic decompensation	0
30	20	M	Manic Depressive Depressed when Rx'd 12/year	Paranoid Schizophrenia	None	Seemed less depressed with longer intervals between episodes could be placebo effect. Patient had recurrent psychotic episodes	Tremor

6. Schou, M., Baastrup, P. C.: "Lithium and Manic Depressive Psychosis." Sandorama, (special edition) 48-49, 1966.
7. Fieve, R. R., Platman, S. R., Plutchik, R.: "The Use of Lithium in Affective Disorders—Part II: Prophylaxis of Depression in Chronic Recurrent Affective Disorder." *Amer. Journ. of Psych.*, 125:492-498, 1968.
8. Spring, G. K., Schweid, D., Steinberg, J., Bond, O.: "Prophylactic Use of Lithium Carbonate?" *JAMA*, 208:1901-1903. 1969.
9. Cade, J. F. J.: "Lithium Salts in the Treatment of Psychotic Excitement." *Med. Journ. Aust.*, 36:349-352, 1949.
10. Gershon, S., Trautner, E. M.: "Treatment of Shock Dependency by Pharmacological Agents." *Med. Journ. Aust.*, 1:783-787, 1956.
11. Gershon, S., Yuiviler, A.: "Lithium Ion: A Specific Psychopharmacological Approach to the Treatment of Mania." *Journ. Neuropsychiat.*, 1:229, 1960.
12. Fieve. R. R., Platman, S. R., Plutchik, R.: "The Use of Lithium in Affective Disorders—Part I: Acute Endogenous Depression." *Amer. Journ. Psych.*, 125:4, 487-491, 1968.
13. Andreani, G., Caselli, A., Martilli, G.: "Clinical and Electrographic Findings in the Treatment of Mania with Lithium Salts." *G. Psichiat. Neuropat.* 83:273-328, 1958.
14. Vojtechovsky, M.: Zkusenostis s Lecbau Salemi Lithia Problemy Psychiatrie V Praxia ve Vyzkumo. Praha, 1957.
15. Dyson, W., Mendels, J.: "Lithium and Depression." *Current Ther. Res.* 10:601-608, 1968.
16. Fries, H.: "Experience with Lithium Carbonate Treatment at a Psychiatric Department in the Period 1964-1967." *Acta Psychiat. Scand (suppl)* 207:41-43, 1969.
17. Callaway, C. L., Hendric, H. C., Luby, E. D.: "Cutaneous Conditions Observed in Patients During Treatment with Lithium." *Amer. J. Psychiat.*, 124, 1968.
18. Fieve, R. R., Platman, S. R.: "Lithium and Thyroid Function in Manic Depressive Psychosis." *American Journ. of Psych.* 125:4, 526-530, 1968.

Speech Therapy for the Mildly Dysphasic Patient: When is it Indicated?

By Judy Spector Huret, M.A. and Henry B. Betts, M.D./Chicago

Experience in treating over 200 mildly dysphasic patients at the Rehabilitation Institute of Chicago, a hospital for the physically disabled which is a component of the Northwestern University-McGaw Medical Center, has resulted in isolating several criteria that a physician may utilize to make a quick, accurate assessment of such patients' potential for progress in language therapy.

Mild dysphasia may be defined as a partial loss of language, resulting in some obvious decrease in fluency of speech or in facility of comprehension following a cerebro-vascular accident, traumatic head injury, or neurosurgery.[1] When a patient leaves the general hospital with symptoms of aphasia, he is usually followed as a matter of course for residual physical impairment. During a recheck, a physician may diagnose the residuals of a mild but persistent dysphasia as well. Questions such as "Could the patient benefit from speech or language therapy?" and "Could therapy help him to resume a style of living closer to the one he had prior to his illness?" may arise.

Rationale

If the physician can answer "yes" to most of the following questions at the time of the recheck, the patient is probably a good candidate for speech therapy. In all cases, although "speaking" is given as the primary language dimension, the need to read, write and understand may be inferred.

1. *Does the patient need to speak better to get along in his job or at home?*

 This question involves the patient's actual daily language demands. For example, someone returning to an executive position will need far better language control than someone returning to a position as a maintenance man. A homemaker with young children needs more language than someone living alone who has few business or social contacts.

2. *Is the patient motivated to improve his speech and other language skills?*

 This question is aimed directly at the patient; no amount of concern from the family or employer can be substituted for the patient's own desire to improve his skills. The more motivated the patient is, the better his chances to improve. On the other hand, if the patient is anxious and compulsive, his prognosis is poorer.

3. *Is there a concerned relative, friend, or sponsor?*

 Emotional support during the sometimes precarious recovery period is vital. Family and friends can help a patient cope with his failures and be proud of his progress. They can also provide additional practice at home with the guidance of the trained speech pathologist.

4. *Is the patient's neurological condition stable?*

 If the patient is having seizures which are medically uncontrolled, or transient ischemia, or if his condition is characterized by progressive neurological deterioration, significant functional progress in therapy may be decreased.

5. *Is the patient's general physical health relatively stable?*

 It has been found that regular attendance at therapy is important to maximize



JUDY SPECTOR HURET, M.A., is Assistant Director of the Speech Pothology Department, Rehabilitation Institute of Chicago. Mrs. Huret olso is on Instructor in the Department of Rehabilitation Medicine at McGaw Medicol Center, Narthwestern University.



HENRY B. BETTS, M.D., is Vice President and Medical Director of the Rehabilitatian Institute af Chicago. Dr. Betts is Chairman and Professar af the Department of Rehobilitation Medicine at McGaw Medical Center, Northwestern University.

Potential for Language Therapy

(Patient's Name:)_____

DIRECTIONS: Circle the appropriate rating for each criterion. Total each column. Multiply by the numerical weight given (1, 2, 3). Add the totals. Overall TOTAL score may be interpreted as follows:

With a Score of:	Prognosis Is:
8 to 12	Poor
13 to 16	Fair
17 to 20	Good
21 to 24	Excellent

CRITERION	weight	RATING 1	2	3
Need to Speak*		minimal	fair	strong
Desire to Speak*		minimal	fair	strong
Emotional Support		minimal	fair	strong
Neurological Status		unstable	usually stable	stable
General Health		poor	variable	good
Recency of Onset		over 2 yr.	6 mo. to 2 yr.	0 to 6 mo.
Age		over 60	50 to 60	under 50
Accessibility of Treatment		inaccessible	somewhat inaccessible	readily accessible
Number of Items Circled Per Column:		_____	_____	_____
Multiplied by Weight:		1	2	3
SUBTOTAL:		_____ +	_____ +	_____ = TOTAL

*. . . listen, read, and write also implied.

progress. The patient with recurring respiratory or gastric ailments which necessitate frequent absences from therapy sessions is generally a poor treatment candidate.

6. *Was the onset of the patient's dysphasia within the last six months?*

The period of spontaneous recovery from CVAs is generally accepted as between three and six months post onset.[2-4] Progress with these patients is usually better when therapy is initiated early.[5] For traumatic injuries, progress proceeds more slowly but over a longer period of time. For all patients, early intervention is desirable.

7. *Is the patient under 50 years of age?*

In general, the younger the patient is, the better the chances are for significant progress.[6]

8. *Is speech therapy readily available to the patient?*

Distance, ease of transportation, availability of a certified speech pathologist, and financial factors also must be considered. For example, it may be more reasonable for a patient who lives quite far from a rehabilitation center to be seen for an evaluation, follow a home program, and be periodically rechecked than to expend substantial time, money, and energy in regular therapy attendance.

For convenience, the checklist above can be used to quickly assess a patient's potential to benefit from speech therapy.

Procedures

The checklist is to be filled out on the basis of informal conversation with the patient and his family and by a rapid review of the history.

The physician evaluates each criterion and circles the appropriate rating. For example, if a patient's job involves telephoning, the physician would circle STRONG for Need to Speak. If a patient lives close to a clinic offering speech pathology but has no means of transportation, the physician would circle SOMEWHAT IN-

ACCESSIBLE for Accessibility of Treatment. The ratings would be 3 and 2, respectively.

After rating each item, the number of items circled in columns 1, 2, and 3 are totaled. Each total is then multiplied by the weight given. The subtotals are added to yield the TOTAL. A key for interpretation is given at the top of the checklist.

Patients with ratings above 17 may be considered good to excellent candidates for language rehabilitation. A qualified speech pathologist may be located by consulting the Directory of the American Speech and Hearing Association.[7]

Summary

In many cases, adults with mild residual language disabilities of neurological origin can make significant functional language recovery with the help of structured speech therapy. The responsibility of referral to a qualified speech pathologist rests with the physician. A simple checklist has been given to help physicians determine the potential for their mildly dysphasic patients to benefit from language therapy. A few minutes taken to analyze eight critical criteria may help such patients to lead more productive lives. ◄

References

1. H. Goodglass and E. Kaplan. The Assessment of Aphasia and Related Disorders. Lea and Febiger. Philadelphia. 1972.
2. E. Sands, M. T. Sarno, D. Shankweiler, "Long-Term Assessment of Language Function in Aphasia Due to Stroke," *Archives of Phys. Med. & Rehab.*, Vol. 50, April, 1969.
3. M. T. Sarno and E. Levita, "Natural Course of Recovery in Severe Aphasia." *Archives of Phys. Med & Rehab.*, Vol. 52, April, 1971.
4. G. L. Culton, "Spontaneous Recovery from Aphasia," *J. SP. & Hrg. Res.*, Vol. 12, Dec. 1969.
5. Sands, Sarno & Shankweiler, *op. cit.*
6. *Ibid.*
7. American Speech and Hearing Association, 9030 Old Georgetown Road, Washington, D.C. 20014.

Neuromuscular Dysfunctions of the External Sphincter

(Continued from page 499)

tion of the lower urinary tract. In particular, these studies are valuable when clinical findings are equivocal. Also, in infants with meningomyelocele an electromyograph of the sphincter is probably the most useful test in assessing the sphincteric function or neuromuscular dysfunction of the lower urinary tract.[11]

Summary

Based on urodynamic and electromyographic studies performed on 65 patients with neuromuscular dysfunction of the lower urinary tract, a new clinical classification of dysfunctions of the external urinary sphincter is presented. The practical application of the classification as it relates to diagnosis and management in urologic practice is discussed. ◄

References

1. Emmett, J. L., Daut, R. V. and Dunn, J. H.: "Role of the External Urethral Sphincter in the Normal Bladder and Cord Bladder." *J. Urol.* 59:439, 1948.
2. Baumrucker, G. O.: "Management of the Paralyzed Bladder." *Arch. Surg.* 56:484, 1948.
3. Cardus, D., Quesada, E M. and Scott, E B.: "Studies on the Dynamics of the Bladder." *J. Urol.* 90:425, 1963.
4. Scott, F. B., Quesada, E. M., and Cardus, D.: "Studies on the Dynamics of Micturition: Observations on Healthy Men." *J. Urol.* 92:455, 1964.
5. Scott, F. B., Quesada, E. M., and Cardus, D.: The Neurogenic Bladder, Edited by Boyarsky, S., Baltimore: The Williams and Wilkins Co., 1967 p. 106.
6. Abramson, A. S., Roussan, M. S., and D'Oronzio, G.: "Method for Evaluating Function of the Neurogenic Bladder." *JAMA* 195:554, 1966.
7. Abramson, A., Boyarsky, S., Roussan, M. and Freedman, H.: "Simultaneous Cystometry and Electromyography, A Preliminary Report." Proc. 11th Ann. Clin. Spin. Cord Injury Conference, Bronx, New York: 107-121, 1952.
8. Whitaker, J., Johnston, G. S.: "Estimation of Urinary Outflow Resistance in Children: Simultaneous Measurement of Bladder Pressure. Flow Rate and Exit Pressure." *Invest. Urol.* 3:379, 1966.
9. Currie, R. J., Bilbisi, A. A., Schiebler, J. C., and Bunts, R. C.: "External Sphincterotomy in Paraplegics: Technique and Results" *J. Urol.* 103:64, 1970.
10. Zinner, N. R., Ritter, R. C., Sterling, A. M., Harding, D. C. and Baker, D. W.: "Clinical Applications of Drop Spectrometry as a Non-Obstructive, Non-Interfering Method for Analyzing Hydrodynamic Properties of Human Urination." *J. Urol.* 102:485, 1969.
11. Chantraine, A., Lloyd, K. and Swinyard, C.: "The Sphincter Ani Externus in Spina Bifida and Myelomeningocele." *J. Urol.* 95:250, 1966.

Abdominal Wall Abscess in an Infant

By Raymond J. Romanus, M.D./Blue Island

Abdominal wall masses and abscesses in children may present a difficult diagnostic problem. Most abdominal wall masses and abscesses are considered to be of a serious nature and related to intra-abdominal disease. Neuroblastomas, Wilms' tumors (nephroblastoma), tumors of the liver, multicystic kidneys and mesenteric cysts are perhaps the most commonly diagnosed masses. The inflammatory lesions usually include psoas and appendiceal abscesses, intussusception and volvulus. This report, however, details the relatively benign nature of an abdominal wall abscess. This is an unusual case of a 9-month old-girl who presented with a right lower quadrant mass and inability to extend her right hip.

Case Report

A 9-month-old Negro girl, born full term with normal growth and development, was examined by a physician for fever and cough of several days duration. The physical examination at that time revealed no cause for the fever and she was treated symptomatically. Throat culture revealed a normal flora. Three days later, she was seen in the Emergency Room because the parents noted that she was unwilling to extend her right hip and held it in afflexed position. The mother also observed a mass which had not been present previously in the right lower quadrant. There was no history of trauma, diarrhea or vomiting and the appetite had been normal. On physical examination the infant was toxic, febrile (103°F) and held the right thigh flexed against the abdomen. She experienced pain and discomfort upon extension of her thigh. There was an obvious mass 2 x 3 cm. above the inguinal ligament at the level of the anterior-superior iliac spine. The overlying skin was tense, and no evidence of trauma or puncture wound. The mass was warm and tender to palpation. There was no guarding or tenderness except in the region of the right lower quadrant. Bowel sounds were normal. The rectal examination revealed no masses and no tenderness was elicited. The white blood count was 12,200 with 54% lymphocytes and 36% neutrophils. The hematocrit was 33 Vol.% and a urinalysis was unremarkable.

Upon admission to the hospital, she was febrile and the mass became localized and fluctuant. The patient was treated with Methicillin. A flat plate of the abdomen revealed normal gas pattern and psoas muscle margins, with no evidence of free air, free fluid or ileus. A barium enema was normal. After admission, the mother was asked to demonstrate the method of changing the child's diaper. The mother, who was right-handed, placed the pins in her mouth while adjusting the diaper. The point of the pin was inserted in the direction of the fluctuant mass. No history of a diaper pin stick could be elicited from the parents.

An incision and drainage under local anesthesia revealed an abscess cavity containing purulent fluid extending down to the muscular layers of the abdomen. The area was irrigated and packed loosely with iodoform gauze which was removed within 24 hours. Postoperatively, the patient was treated with warm wet dressings and became afebrile. The range of motion of the hip returned to normal within several days. Cultures of the throat and nose revealed alpha hemolytic streptococcus and some Neisseria strain. The urine culture revealed no growth, the stool cultures revealed no pathogenic organisms. The culture from the abscess cavity grew staphylococcus aureus coagulase positive, resistance to penicillin and demethylchlortetracycline.

In an effort to discover the source of this infection, cultures of the throat and fingers were done on all members of the family that were known to have contact with the infant. This included the mother, father, grandmother and a babysitter. The cultures revealed normal flora and no staphylococcus aureus could be isolated from any of these people.

Discussion

Most literature on abdominal masses in children discuss the intra-abdominal origin of the

RAYMOND J. ROMANUS, M.D., is from the Department of Surgery, Blue Island Medical Center, Blue Island.

lesion. The masses considered most often in the right lower quadrant of the abdomen include intussusception, renal cysts and tumors, and volvulus.[1] The appendiceal abscess is the most frequently considered inflammatory mass followed by right psoas muscle abscess. The authors of a large series of pyogenic abdominal wall abscesses concluded that the pathogenesis was often obscured, but staphylococcus aureus was the most common organism cultured. In this case, the abscess was in the deep subcutaneous layer of the abdominal wall.[2] Common intra-abdominal lesions (volvulus, intussusception and appendicitis) were excluded by the lack of other gastrointestinal symptoms as anorexia and vomiting in the history of the present illness. The roentgenographic studies further confirmed the physical findings and aided in the differential diagnosis. A psoas muscle abscess was also ruled out by the location of the lesion in this patient. The hip flexion was considered secondary to irritation of the abdominal musculature.

Although staphylococcus aureus could not be successfully cultured from any members of the family with immediate contact, it is still likely that the organism was introduced into the deep subcutaneous tissue from a puncture by the diaper pin. This hypothesis is strengthened by the location of the subcutaneous abscess in the right lower quadrant. This is possible when changing diapers, especially from the right side of the infant. Staphylococcus aureus has been shown to be a prevalent organism on the skin of the abdominal wall in infants especially in the groin and perineal areas and an abscess could easily be seeded with staphylococcus aureus by a diaper pin puncture. A nidus of tissue or inoculum of bacteria inserted by the pin tip in the subcutaneous tissue was likely the origin of this abscess.[3]

This is a somewhat unusual cause of an abdominal wall abscess. Considering the frequency with which diaper pins are jabbed into infants during changing, it is surprising that this condition does not occur more frequently. This case presents an additional diagnostic consideration in infants with right lower quadrant masses or abscesses. ◄

References

1. Arey, J. B.: "Abdominal Masses in Infants and Children." *Pediatric Clinics of North America.* 10:665-689, 1963.
2. Dall, D. M.; Cywes, S.: "Pyogenic Abdominal Wall and Psoas Abscesses in Children." *South African Medical Journal.* 40:532-534, 1966.
3. Thompson, D. J.; Gezon, H. M.; Hatch, T. F.; Rycheck, R. R.; Rogers, K. D.: "Sex Distribution of Staphylococcus Aureus Colonization and Disease in Newborn Infants." *New England Journal of Medicine* 269:337-341, 1963.

Treating Psoriasis of the Scalp with A New Corticosteroid Lotion

(Continued from page 504)

Signs and Symptoms

The following signs and symptoms were analyzed for treatment differences:

Excoriation
Inflammation
Scaling
Crusting
Pruritus

All other parameters had too few subjects with the condition initially.

Only patients exhibiting the symptom initially were included.

Significant differences are indicated as in Table 2.

Conclusion

In a series of multicentric, randomized double-blind evaluations of the topical use of betamethasone valerate lotion 0.1% versus its isopropyl alcohol vehicle (placebo) carried out by 15 investigators in psoriasis of the scalp, the active lotion proved highly effective statistically. The alcohol vehicle, although less effective, apparently evidenced a beneficial action. Such action may serve to enhance the therapeutic effectiveness of betamethasone valerate.

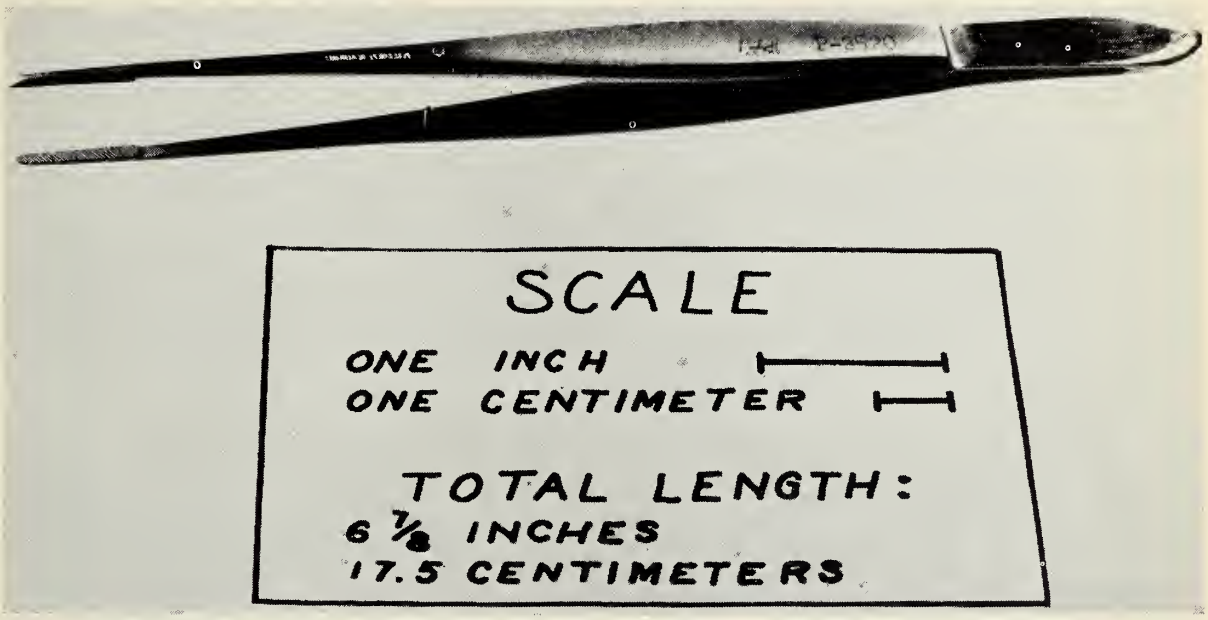
Considering the results achieved in these studies, the 0.1% betamethasone valerate lotion should prove to be a highly useful preparation in psoriasis of the scalp where therapy in the past has been so difficult for most patients. ◄

References

1. Stoughton, R. B., "Corticosteroids in Psoriasis," *Proc. Int. Symp.,* (E. M. Farber and A. J. Cos, Eds.), Stamford Univ., California, p. 367, 1971.
2. Harris, J. J., "A National Double-blind Clinical Trial of a New Corticosteroid Lotion: A 12 Investigator Cooperative Analysis," *Curr. Therap. Res.* 14 #9, Sept., 1972.
3. Investigators were located in Westport, Conn.; Boston, Mass.; White Plains, New York; Balt., Maryland; Summit, N.J.; Decatur, Ga.; Denver, Colo.; Los Angeles, Calif.; Atlanta, Ga.; Iowa City, Iowa; Memphis, Tenn.; Dallas, Texas; Minneapolis, Minn.; Nutley, N.J.; and Chicago, Ill.

Rediscovery of Cushing's Forceps

By Hugh A. Johnson/Rockford



A surgical instrument that can do the work of two might increase efficiency in the operating room only if it is not a compromise and does both jobs well.

I was looking for one forceps to do three jobs: a skin forceps gentle enough to pick up unanesthetized tissue, yet a forceps long enough to use deep in the pharynx, a forceps with diamond jaws strong enough to pick up a needle. It is difficult to have a special instrument made.

It occurred to me that in the past there were certainly surgeons who had the same needs as I. Neurosurgeons antedated plastic surgeons in the search for gentle instruments. Surely one of them had solved my problem before. The fine forceps many of us use are James Barrett Brown's modification of Adson's forceps. Adson was the longtime chief of neurosurgery at Mayo's. I checked the instrument lists and found Harvey Cushing's name.* Cushing's forceps are now available with the diamond-jaw insets (Padgett Instrument Co., etc.). This forceps has proved itself after two years of heavy duty. I think others will find it useful. To prove to yourself that it is atraumatic, have your assistant pick up your thumb web, first with the forceps you are now using and then with the Cushing's forceps. (If the assistant hurts with both pair of forceps a search should be begun for one less heavy handed.) The diamond jaws show no wear after two years of prolonged use. The serrations are such that 6-0 sutures (and even single hairs) are firmly gripped. In addition, the handles are gold plated for easy identification.

Harvey Cushing, perhaps our most famous neurosurgeon, lived 1869-1939. He was fourth in a direct line of physicians who had gone out as pioneers to the western reserve (Cleveland). He graduated from Yale and Harvard Medical School, then went to Johns Hopkins for four years. After training in Europe he became Professor of Surgery at Harvard and Surgeon-In-Chief to the Peter Bent Bringham Hospital. He became internationally famous after publication of his work on the pituitary in 1912. (In 1925 he wrote The Life of Sir William Osler, *which won the Pulitzer Prize for Biography.) Having studied under both Halsted and Kocher, he undoubtedly became quite aware of the design of surgical instruments.*

Summary

Surgeons in the past had more skilled instrument makers. Before trying to design an instrument today, one should search existing inventions, for perhaps just such a needed instrument has already been designed. I have rediscovered Cushing's forcepts to answer all my needs, gentle to tissue, strong enough to pick up a needle. ◄



HUGH A. JOHNSON, M.D., Rockford, maintoins o private practice in plostic and recanstructive surgery. Dr. Jahnson, o groduate of Northwestern University Medical School, serves as o consultont to the burn unit at Cook Caunty Hospital, Chicogo.

RAPE

By Robert Hartman, M.D./Jacksonville
Chairman, ISMS Committee on Maternal Welfare

There are few experiences in life so debasing as to be the subject of sexual assault. Even those who are called upon for aid may contribute to further dehumanizing trauma. The skepticism of the investigating authority, the probing of the examining physician, the embarrassment of public testimony and cross examination all add to the reticence and suffering of the victim.

This article does not purport to offer anything new, but rather reflects the consensus of the members of the Maternal Welfare Committee of the Illinois State Medical Society regarding this distasteful subject. Two areas of major and one of perhaps lesser medical concern are recognized: psychologic trauma, physiologic sequellae and, proof; physical or forensic.

Psychologic Trauma

Much could be written regarding the damage to the psyche. Perhaps mentioning a few of the major problem areas plus a sketchy recapitulation of suggested solutions will suffice.

While the extent and type of injury may vary with the age and previous sexual experience of the patient, all victims deserve to be treated with decency and delicacy. All too often the physician enters the examining room, basically unhappy with his present role, makes a blunt introduction, throws back the drape, commands "drop your thighs apart" and forthwith attempts to insert the cold, unyielding speculum. Prior to any attempts at physical examination, an effort should be made to establish some type of rapport and to let the patient tell her story. In the case of the very young one must constantly be reminded that skilled professional management is critical in preventing scars which may make a psycho-sexual cripple of the patient. Adequate verbalization and extreme gentleness are essential. The examination of the prepubertal and adolescent child has been well described and the interested physician is referred to standard texts such as those of Hoffmann,[1] Schaufler,[2] and others. These women should be spared for gauche or unwitting queries or suspicion. Reports of such questions as "did you invite it" or "did you enjoy it" are all too commonplace.

Private privileged conversation with complete assurance of confidentiality should be afforded in each instance, and the opportunity to facilitate face-saving must be searched for carefully and enlarged upon if found.

Finally, the interview-examination should not be terminated without delineating specific directions for obtaining follow-up counseling and care.

Physiologic Sequellae

Several methods for the avoidance of pregnancy have been suggested. Probably the basic regimine consists of the administration of 25 mgm. of diethylstilbesterol every 12 hours for five consecutive days. While generally effective, maximally optimum results with this therapy are obtained with administration in the post-ovulatory or secretory phase of the cycle. In the event the attack was experienced earlier, a hostile endometrium is said to result from the administration of 5 mgm. of D.E.S. daily for 20 to 25 days. The *A.C.O.G. Technical Bulletin*[3] suggests an alternative of giving 100 mgm. of Depo-Provera (medroxyprogesterone) intramuscularly; whereas Craver[2] reports additional suggestions of either 20 mgm. of Premarin® (natural conjugated estrogens) I.V. for two consecutive days or ethinylestradiol 2.5 mgm. orally for five days. Nausea, sometimes of considerable severity, may complicate the use of the high doses of estrogen, but patient motivation plus the prescription of antiemetics will usually secure good cooperation. Pain at the injection site is not uncommon, along with the added problems of mammalgia and prolonged menses.

Because of the reported etiologic role in the occurrence of clear cell carcinoma of the vagina in the daughters of women treated with D.E.S., it is recommended that the presence of a previously existing pregnancy be ruled out by a

testing method of great accuracy to avoid both unnecessary and potentially dangerous medication. Most authorities now recommend that when pregnancy does occur in spite of medical prophylaxis, the patient should be apprised of the availability of voluntary abortion.

Prophylaxis of possible venereal disease is quite another matter but one of equal importance. While 4,800,000 units of aqueous Penicillin G will prevent most instances of gonorrhea, proof of efficacy by subsequent follow-up, including cultures, is necessary. It should be remembered that the prophylactic dose of Benzathine Penicillin G against syphilis does not produce adequate blood levels to be of value against Nosserian infections. One gram of probenicid given orally one hour before the administration

The other less common venereal diseases are resistant to penicillin and broad prophylactic coverage is said to be obtainable by administration of 500 mgm. of tetracycline four times daily for 15 days.

It is probably superfluous to emphasize the fact that the use of any antibiotic should be preceded by careful questioning regarding sensitivity and the adequate warning of the symptoms of yeast overgrowth and/or intestinal upset. Likewise, it is probably unnecessary to point out that intramuscular medication is usually more efficacious than oral.

Proof, Physical and Forensic

Primarily the determination of rape is the function of the judicial process and the physician should carefully abstain from pronouncements. However, the collection of data is often delegated in a major part to the doctor.

One must not forget the rights of the patient and to this end, her consent must be secured. Having secured this, careful observation is required. Examination of the patient's clothing should include careful inspection; tears should be described and stains identified. Photographs are of great help in this regard as well as the recording of physical findings. The appearance of the patient, her demeanor, and sobriety all should be noted. In the latter instance, blood alcohol levels are often more acceptable than clinical impressions and may differentiate between shock-hysteria and the like. Abrasions, bruises, lacerations and other marks of violence should be accurately located and described. The recovery and typing of loose hairs may be of more than academic importance as may blood or other foreign material found upon the person of the victim.

The presence of sperm or prostatic fluid on clothing, vulva or vagina may be determined and the laboratory should be able to perform the acid phosphatase test and semen typing as well as to identify sperm. Fresh moist material obtained by speculum from the vagina is probably most desirable, but whatever material is tested must be accurately identified and the chain of control of positive identity is essential. If the examiner is physically unable to hand the material to the technician, he must devise a fool proof method of delivery, by conscientious personnel or registered mail with a return receipt demanded.

Finally, it should be emphasized that the services of a gynecologist are not required in the investigation of this insult and in some cases it may be preferable not to "call in a specialist." The services most required are diligence, accuracy, acuity, and perhaps above all empathy and understanding. ◄

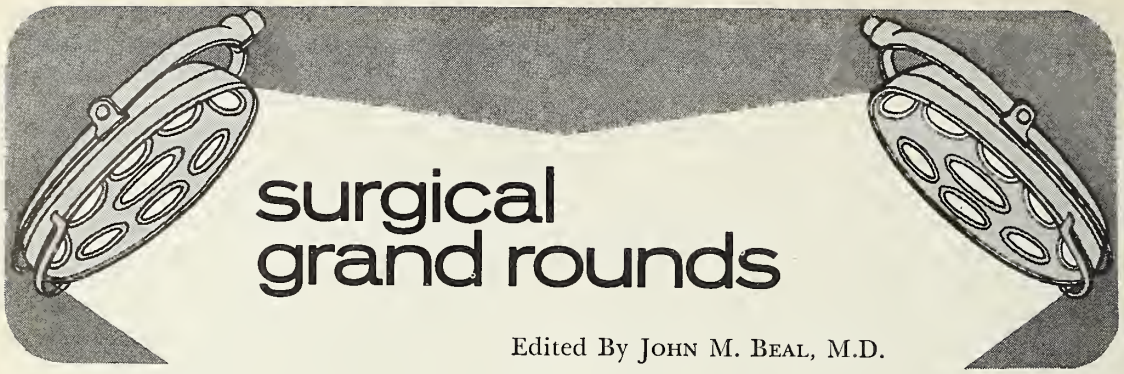
Cause of Idiopathic Portal Hypertension

Idiopathic cases of portal hypertension may actually be due to occlusion of intrahepatic portal vein radicles by organized thrombi that are undetectable by available diagnostic techniques, says Dr. James L. Boyer and his associates at Yale University School.

Four cases of severe portal hypertension with splenomegaly and esophageal varices were designated idopathic after surgical wedge biopsy of the liver, portography, and measurement of wedge hepatic vein pressure did not reveal the cause.

However, postmortem investigation of the intrahepatic vasculature by vinylite-injection corrosion in three cases and dissection in one, showed extensive attenuation and occlusion of intrahepatic portal vein branches by organized thrombi. Dr. Boyer says.

Dr. Boyer is currently affiliated with the Pritzker School of Medicine, University of Chicago *(Medicine 53:77-91, 1974)*.



Edited By John M. Beal, M.D.

Hyperparathyroidism and Pregnancy

Surgical Grand Rounds are held weekly on Tuesdays at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion. Patient presentations from Northwestern Memorial and Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of December 18, 1973.

Dr. William Finn: A 38-year-old Black woman came to the Emergency Room of Wesley Pavilion, October 16, 1973. She stated that she was approximately one month pregnant with her ninth child, confirmed by a positive pregnancy test approximately one week prior to being seen. For the past month she had experienced anorexia, nausea and vomiting of mucus and ingested food, approximately once a day and these symptoms had become progressively worse during the preceeding 48 hours so that she had become unable to tolerate oral intake. She stated that she had experienced similar symptoms during her previous pregnancies. A diagnosis of hyperemesis gravidarum was made and the patient was admitted to the hospital. She was treated initially with intravenous fluid until oral intake was tolerated. The routine SMA[14] at the time of admission reported a serum calcium of 15.3 mg%. After 24 hours of intravenous fluid therapy, the level was recorded as 13.5 and the patient received a low calcium diet. She was discharged on the tenth hospital day and was followed as an outpatient. When discharged, her serum calcium level was 12.5 mgm%.

One week later in the outpatient clinic, her calcium was 13.5 mgm% and admission to the hospital was advised for further diagnostic evaluation. She was admitted for the second time on November 2, 1973. Careful questioning revealed a six month history of progressive weakness, lethargy, easy fatigability in addition to the nausea, vomiting, anorexia previously mentioned. She denied hematemesis, or melena, fever, chills, flank pain, hematuria or passage of urinary calculi. She had not been exposed to tuberculosis and a history of hepatitis or jaundice was absent. The patient was taking no drugs, antacids or vitamin compounds. Obstetrical history revealed that she was a gravida 10, para 8, Ab 1 with eight normal, spontaneous, vaginal deliveries. However, her last child had suffered neonatal seizures which she had been told resulted from "low calcium in the baby's blood."

The admission physical examination was unremarkable. Laboratory included a normal urinalysis, hematocrit of 35%, hemoglobin of 12 gm. Alkaline phosphatase, SGOT, LDH, CPK, X-rays of the skull, chest and bones of the hands were reported to be normal. The admission serum calcium was 13.5 and the serum phosphorus was 2.1 mg.%. T_3 and T_4 were normal, as was the serum protein electrophoresis. Tubular re-absorption of phosphate was performed on two occasions and was reported as 77% and 30% (normal 85-95%). Serum assays of parathyroid hormone were performed and reported as 540 and 480 units (normal range of 90-360). A diag-

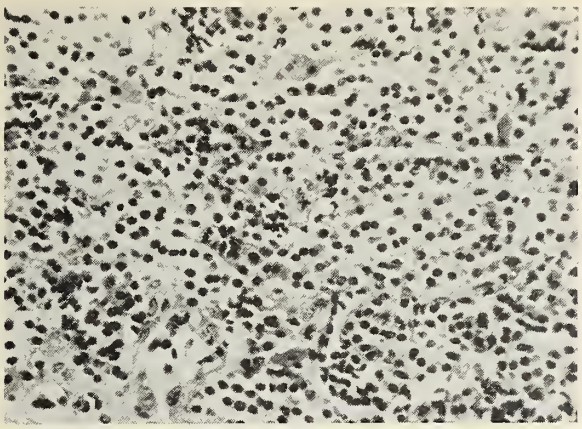


Figure 1. Medium power magnification of the parathyroid adenoma. Note absence of fat and prominent vascularity.

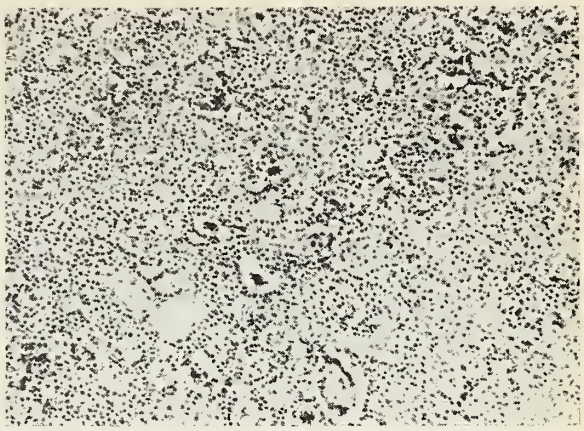


Figure 2. Parathyroid adenoma. Higher magnification showing predominance of chief cells and moderate degree of pleomorphism.

nosis of primary hyperparathyroidism was made and on November 28, 1973, the patient was taken to the operating room for exploration of the neck. Four parathyroid glands were identified and the left lower parathyroid gland was replaced by a parathyroid adenoma. The left and right lower parathyroid glands including the adenoma were excised and sent to the pathologist for frozen section to confirm the diagnosis. The patient did well post operatively. On the second post operative day, her serum calcium was 7.5 and her serum magnesium was 1.0 mgm%. She received the intravenous infusion calcium gluconate and intra-muscular admistration of magnesium sulfate and responded well. At the time of discharge from the hospital, her serum calcium level was 9.0 mgm and she was asymptomatic.

Dr. Hector Battifora: Three parathyroid glands were received. The largest one weighed 630 mg.; the other two were quite small and estimated to weigh about 25 mg each. As shown in Figure 1, the largest specimen had all the histologic features of an adenoma or a hyperplasia of the parathyroid, namely, disappearance of the adipose tissue normally found in the parathyroid parenchyma with replacement by sheets of polyhedral cells supported by a highly vascular stroma. The cell type is shown better in Figure 2 where a slight degree of pleomorphism can be appreciated. Mitoses are not present.

In order to distinguish between hyperplasia and adenoma, one has to have an idea of the appearance of the other parathyroid glands. In some cases of adenoma, a careful search can reveal the presence of a compressed, but otherwise normal parathyroid about the capsule of the adenoma. In most other cases, as the present one, normal parathyroid tissue has been submitted by the surgeon and its identification clearly rules out a generalized hyperplasia of the parathyroid. So, we must conclude that this lesion represents an adenoma. Although the rare carcinoma cannot be totally excluded, the absence of mitoses, vascular invasion and the apparent encapsulation of the tumor makes this a very remote possibility.

Dr. William Finn: This case is interesting in several respects. First of all, the clinical presentation of primary hyperparathyroidism has changed significantly over the past 30 years. Originally, hyperparathyroidism was felt to be a disease of bone, and, indeed, before 1947, the incidence of bone disease in these patients was 93%, while the incidence of renal disease secondary to hyperparathyroidism was only 37%. The incidence of the diagnosis of hyperparathyroidism in the absence of renal or bone disease was only 2%. Hume, in a review of cases reported from 1953 to 1965, noted that the incidence of bone disease had dropped to 38% while the incidence of renal disease in these patients had risen to 68%. However, the diagnosis was made in only 6% in the absence of renal or bone disease. Cope, in reporting 343 cases in the Massachusetts General Hospital in 1966 noted that the clue to the diagnosis of hyperparathyroidism was renal disease in fully 60% of the cases, while associated bone disease was found in only 25% of the cases.[1] In 16%, hyperparathyroidism was detected without renal or bone disease. A report of 57 cases of primary hyperparathyroidism from the National Institutes of Health at this time noted the incidence of bone disease was 9%, the incidence of renal disease 22%, and more than 60% with evidence of neither renal nor bone disease, but with a cluster of non-specific subjective symptoms of weaken, lethargy, easy fatigue, anorexia, nausea, vomiting and other subjective complaints.

To some extent, the widespread use of comprehensive biochemical screening tests has led to the detection of hyperparathyroidism more often. However, it is hoped that the suspicion of primary hyperparathyroidism will be raised in patients such as this one who was presented today with non-specific, subjective complaints, otherwise unexplained.

The second interesting point in the present patient is that she was pregnant at the time the diagnosis of hyperparathyroidism was made. Friderichsen is usually credited with describing the first case of neonatal tetany secondary to maternal hyperparathyroidism.[2] In 1962, Ludwig reviewed case reports of some 34 pregnancies in 21 women with known hyperparathyroidism and he stated that the pre and perinatal morbidity rate in these infants was approximately 50%, and that the incidence of neonatal tetany was approximately 25%.[3] He, therefore, concluded that parathyroidectomy was indicated in any patient in whom hyperparathyroidism and pregnancy co-existed. A review of this problem from Copenhagen drew several conclusions. First, fertility, gestation, labor and delivery do not seem to be affected by the primary disease; however, the birth weights of the infants are statistically lower than their normal counterparts and 50% have been below 3,000 grams at birth. Second, the pre and perinatal morbidity rate has been approximately 40% in women with known bone disease secondary to their hyperparathyroidism. Finally, the incidence of the development of neonatal tetany in the surviving infants was approximately 50% and was as high as 90% in mothers with known bone disease. The third interesting aspect of our case is the incidence of hyperchloremic metabolic acidosis in patients with primary hyperparathyroidism. This phenomenon has been described well in the literature and in textbooks and is believed to be a direct effect of parathyroid hormone on the kidney tubules. Severe hyperchloremic metabolic acidosis may develop postoperatively and require aggressive intravenous bicarbonate therapy in order to maintain electrolyte balance. However, this was found usually in patients with severe bone disease secondary to their hyperparathyroidism. Our patient did have some mild metabolic acidosis preoperatively, but this did not result in any significant problems.

Dr. John Beal: What is the mechanism for the tetany in the children?

Dr. William Finn: Well, it's believed to be parathyroid suppression secondary to the passage of calcium across the placenta.

Dr. John Beal: Not due to parahormone?

Dr. William Finn: No, it's not believed to be because there apparently have never been any incidence of bone disease in these infants.

Dr. James Hines: There are three points of interest in this case: 1) The hyperchloremic acidosis was unexplained until the diagnosis of hyperparathyroidism was made. She has had hyperemesis gravidarum with other pregnancies and this usually leads to hypochloremic alkalosis. The hyperchloremic acidosis was reversed by the parathyroidectomy. 2) The epigastric distress of which the patient complained has been related to hyperparathyroidism. The cause is not known. There has been a theory that there is a higher incidence of peptic ulcer disease with hyperparathyroidism. This hasn't held up statistically. Ulcer disease is a common disease in the general public and the incidence is not increased in hyperparathyroidism. Again, the epigastric distress was not present after her parathyroidectomy, although the hyperemesis persisted. 3) The third point is, at what point do you operate on a patient that has a pregnancy? Traditionally, we have waited for the middle trimester. In the case presented, we operated at the end of the second month because of the possibility of hyperparathyroid crisis developing. With our improved anesthesia, many surgeons feel that operations away from the pelvic organs can be safely performed during the late second and third months of pregnancy.

Dr. John Beal: I was interested that the reports indicate that fertility does not seem to be influenced by hyperparathyroidism.

Dr. James Hines: Apparently, the conditions may co-exist, but the awareness of this combination is not widely entertained.

Dr. William Finn: The present patient had already had eight children and seems to illustrate the lack of influence of hyperparathyroidism on fertility.

Dr. John Beal: Also, after one of her previous pregnancies, her child developed tetany indicating that she had the disease then.

Dr. James Hines: A last note is that following parathyroidectomy, both the calcium and the magnesium had dropped significantly producing positive Chvostek's and Trousseau's signs. She responded quickly to intravenous calcium and intramuscular magnesium. ◄

References

1. Cope, O.: "The Story of Hyperparathyroidism at the Massachusetts General Hospital." *N. Engl. J. Med.*, 274: 1174, 1966.
2. Friderichsen, C.: "Tetany in a Suckling with Latent Osteitis Fibrosa in the Mother." *Lancet*, 1:85, 1939.
3. Ludwig, G. D.: "Hyperparathyroidism in Relation to Pregnancy." *N. Engl. J. Med.* 267:637, 1962.
4. Johnstone, R. E. II, Kreindler, T. and Johnstone, R. E.: "Hyperparathyroidism During Pregnancy." *Surg. Gyne. & Obst.*, 40:580, 1972.

Doctor's News

TASK FORCE ENFORCING NARCOTICS LAWS—A Joint Federal/State Task Force of 16 agents are investigating the flow of controlled substances from all physicians, pharmacists, and hospitals, either by prescription or dispensing, and all other legal drug sources to detect how drugs find their way to illicit channels. Northern Illinois will be the center for the Task Forces' activities.

Recent activity by the Illinois Legislative Investigating Commission dramatically documented that some physicians are providing controlled substances to drug misusers. In fact, two physicians received court sentences of five years each, one on 19 counts, the other on 33 counts of Federal Controlled Substance Law violations. Ninety-nine physicians have thus far been named to the Commission.

Some of these individuals were known to be practicing improperly. However, the county medical society had not filed a complaint with Registration and Education. As a result, proposals distasteful to the legitimate physician were made. ISMS has met with the enforcement groups and is developing a medical advisory board system to assist in ferreting out "bad apples." But the county medical society *must* take a leadership role or each and every physician may come under investigation.

MEDICAL LIABILITY COMMISSION NEEDS SUPPORT—Last fall, the Medical Liability Commission was established to bring together organizations representing all fields of medical practice, hospitals and dentistry to seek solutions for the continuing and increasing problems of medical liability.

The success of the Commission depends on the support of physicians at all levels—national, state and local. Suggestions and/or proposals for reducing the problems of medical liability should be forwarded to Richard Bergen, AMA, 535 N. Dearborn St., Chicago, 60610.

ISMS HONORS MEDICAL JOURNALISTS—The 10th annual ISMS Journalism Awards dinner was held June 1, 1974, to pay tribute to outstanding medical journalists in Illinois. The ISMS Council on Public Relations and Membership sponsors the journalism awards competition.

A special award went to Mike Royko, *Chicago Daily News* columnist and two more awards to a 10-time winner, the *Chicago Tribunte* and its' Medical Editor, Ronald Kotulak.

Winners for 1973 were:

SPECIAL AWARDS

Mike Royko, *Chicago Daily News* columnist . . ."A Faceless Man's Plea"
WTTW-TV, Chicago . . ."The Thinking Consumer's Guide to the Drug Store"

NEWSPAPERS SERIES

Chicago Daily News . . . Sandra Pesmen . . ."Babies After 40"
Joliet Herald-News . . . Marlene Stubler . . ."Cancer: It Doesn't Have to Shatter Your Life"

NEWSPAPER FEATURES

Champaign-Urbana Courier . . . Gary Benson . . ."Dyslexia"
Chicago Tribune . . . Ronald Kotulak . . ."Heart Attack"
Rockford Register-Star . . . Barbara Chapman . . ."Is There a Doctor in Town?"
Libertyville Herald . . . Marian Smentek . . ."Alcoholism and its Impact on Women and Teenagers"

GRAPHICS
Joliet Herald-News . . ."It Can Be a Family Affair"

NEWSPAPER COMPREHENSIVE COVERAGE
Chicago Sun Times . . . Robert Hillman & Patricia Anstett . . ."A Comprehensive Look at Cermak Memorial Hospital"
Chicago Tribune . . . Ronald Kotulak . . ."New Research Offers Disease Control Hope"
Clay County Advocate-Press . . . Jack Thatcher . . ."Crisis of Clay County Hospital"

RADIO NEWS SERIES
WMAQ, Chicago . . ."WMAQ Newsprobe: Abortion"

RADIO DISCUSSION
WLS, Chicago . . ."WLS Blood Vigil"
WJOL, Joliet . . ."Don't Call My Child a Brat—The Hyperkinetic Child"

RADIO DOCUMENTARY
WMAY, Springfield . . ."Emergency Medical Technician—Ambulance"

TELEVISION NEWS SERIES
WBBM, Chicago . . ."Cancer"

TELEVISION NEWS DOCUMENTARY
WLS, Chicago . . ."Every Moment Counts"

TELEVISION DOCUMENTARY PROGRAM
WCIA, Champaign . . ."CIA Reports: Ambulances"
WMAQ, Chicago . . ."Cause of Death Unknown"
WMBD, Peoria . . ."Vincent"

PHYSICIANS IN THE NEWS—Recent recipients of Masters degrees from Bradley University, Peoria, are **Drs. Joseph L. Bordenave, Kenneth Furlong** and **Fred Z. White.**

New appointments to the Board of Trustees of the Hektoen Institute for Medical Research of Cook County Hospital are **Edwin L. Brashears, Jr.; Ellsworth E. Hasbrouck, M.D.;** and **Irving Greenberg, M.D.**

Fred Z. White, M.D., Cited For Public Health Contributions



Recently the Illinois Public Health Association presented Fred Z. White, M.D., (left) Chillicothe, with the Award of Merit for his contributions to public health. Dr. White was cited for his work with migrant workers at Princeville, where he is Director of the Migrant Health Clinic.

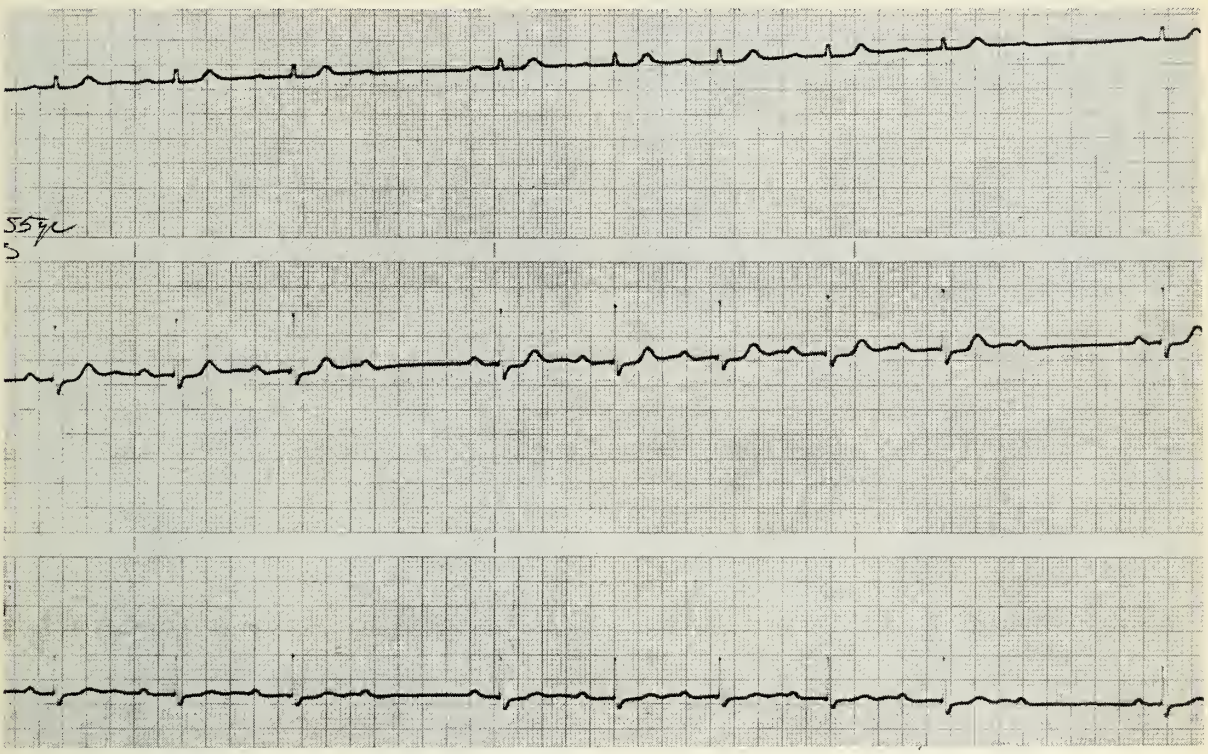
Dr. White also is Director of Carver Family Health Center, Peoria; Co-Director of Family Practice, and Clinical Associate, Peoria School of Medicine.

An active member of the Illinois State Medical Society, Dr. White serves as Trustee from the Fourth District, member of the state HASP Committee, Illinois Foundation for Medical Care and participates on numerous committees. He is Past President of the Peoria Medical Society and Illinois Heart Association.

A Diplomate of the American Board of Family Practice, Dr. White is a graduate of Northwestern University Medical School. He just completed a Masters Degree in education at Bradley University.

ekg of the month

John R. Tobin, M.D., M.S., Rimgaudas, Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., James V. Talano, M.D., Sarah Johnson, M.D. and Rolf M. Gunnar, M.D., M.S./Section of Cardiology, Loyola University Stritch School of Medicine



A 68-year-old man entered the hospital with acute pulmonary edema. He was treated with digitalis and diuretics with good result. On the sixth hospital day he complained of nausea. The simultaneous 3 lead rhythm strip (leads I, II, and III) presented here was taken at this time.

Questions:

1. The ECG shows:

A. Blocked premature atrial beats.
B. Sinus pauses.
C. Type I second degree AV block (Wenckebach block).
D. Type II second degree AV block (Mobitz phenomenon).
E. None of the above.

2. The treatment should include:

A. Pacemaker implantation.
B. Pushing digitalis.
C. Stopping digitalis.
D. Evaluation of the serum electrolytes.
E. None of the above.

(Answers on page 538)

Pediatric Perplexities
Ruth Andrea Seeler, M.D., Editor

Epigastric Pain and Vomiting With or Without a History of Trauma

By Hugh V. Firor, M.D., F.A.C.S., F.A.A.P./Chicago

"Pediatric Perplexities" is a series of encounterable, but slightly uncommon, pediatric disorders which require prompt diagnosis and specific management for a good outcome. The editor welcomes suggestions for types of cases that the readers would like to have presented and discussed.

Case Reports

Patient A, a 2½-year-old boy, was knocked down while playing football with older children. It was uncertain whether he was struck in his flank or his abdomen. He was brought to the emergency room because of pain. Examination revealed a scaphoid abdomen, minimal epigastric tenderness and normal bowel sounds; hematocrit was 36%. He was admitted for observation due to persistance of pain. Twenty-four hours later he vomited; examination then showed minimal abdominal distention, no change in bowel sounds, but increased epigastric tenderness. Hematocrit had dropped to 27%. A nasogastric tube returned bile stained fluid. Abdominal films (Fig. 1) suggested a working diagnosis which was promptly confirmed by upper G.I. series. (Fig. 2).

Patient B, a 5-year-old boy, was admitted one evening because of abdominal pain. The pediatric surgery resident after examining the child decided that he did not have a surgical abdomen, but kept the child for observation because of persistent abdominal pain and ill defined epigastric tenderness. The next morning the child vomited; re-examination revealed a slight increase in epigastric tenderness. Abdominal films were pronounced normal. He now was 18 hours post admission and had vomited four times. The attending pediatric surgeon noted epigastric tenderness and a palpable epigastric mass, and called attention to the paucity of intestinal air in the abdominal films. He suggested a clinical diagnosis which was confirmed within an hour by upper G.I. series (Fig. 3) Surgery was uneventful.

The author is Director, Division of Pediotric Surgery ot Cook County Children's Hospitol ond University of Illinois Hospitol, ond Associote Director, Department of Surgery at Cook County Hospitol.

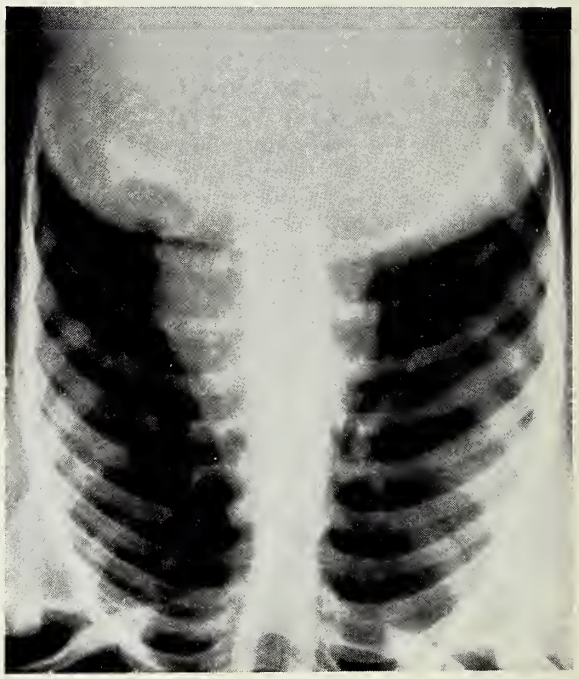


Fig. 1. Upright abdominal film showing an "airless" abdomen beyond the stomach.

On the second post operative day the child's uncle reported that he had fallen from the back of a truck 30 hours before admission.

Discussion

Both boys had an important but uncommon lesion, an intramural hematoma of the duodenum. Although initially described in 1838, duodenal hematoma received little notice and in the ensuing 100 years only 11 cases were recorded. In the next 30 years, 114 cases were reported.[1] Today this entity is seen several times a year in most general hospitals with children accounting for a lion's share of the cases.[1,2]

Antecedent trauma is the important clue to

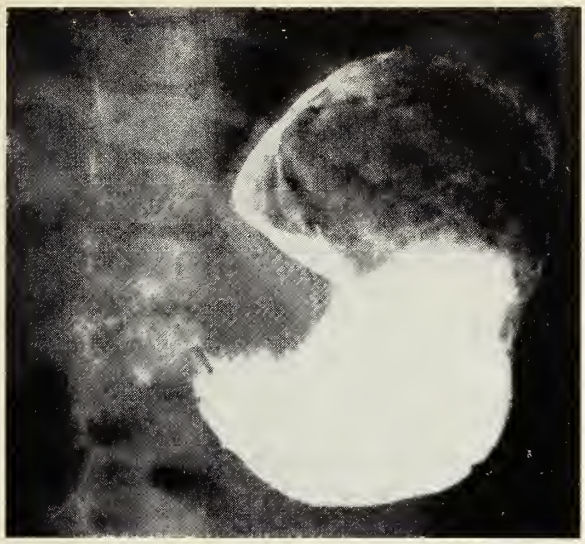


Fig. 2. Barium is retained in stomach and there is irregularity and obstruction of the duodenum.

diagnosis, but, often this history is not obtainable. An adult may not have observed the trauma and a child may have forgotten. The trauma may be surprisingly mild and commonly an interval of a few hours to several days separates the trauma from the onset of symptoms. Trauma is the etiology in all but the exceptional case, although ecchymosis of the abdominal wall is rarely present. Spontaneous occurrence in hemophiliacs and in patients on anticoagulants has been reported.[3,4] At least two cases following small bowel biopsy using a peroral biopsy capsule have been recorded.[5,6]

The association of duodenal hematoma with the "Battered Child Syndrome" has been fairly frequent.

The hematoma results from sudden compression of the duodenum against the vertebral column with tearing of submucosal vessels. Bleeding occurs with gradual accumulation of an intramural clot. After a variable period the clot may elevate the mucosa to the point of producing obstruction. Most commonly the 2nd and 3rd portions of the duodenum are affected but the hematoma may extend from the pylorus to or beyond the duodenojejunal junction (Fig. 4). In some instances the hematoma may obstruct the pancreatic duct and/or the common bile duct (Fig. 5).[7] Perforation into the lumen of the intestine or into the peritoneal cavity is an unusual event.

Persistent abdominal pain, often severe, and repeated episodes of vomiting are the most frequent symptoms. Epigastric tenderness although rarely absent may be surprisingly mild. An epigastric mass is palpable in less than 50% of such



Fig. 3. Obstruction of duodenum by hematoma with concave surface toward the stomach.

children. A drop of hematocrit as noted in patient A occasionally occurs but frank shock is rare in the absence of some associated lesions e.g. splenic or hepatic injury. Associated injury to the pancreas and mesentery are occasionally found.

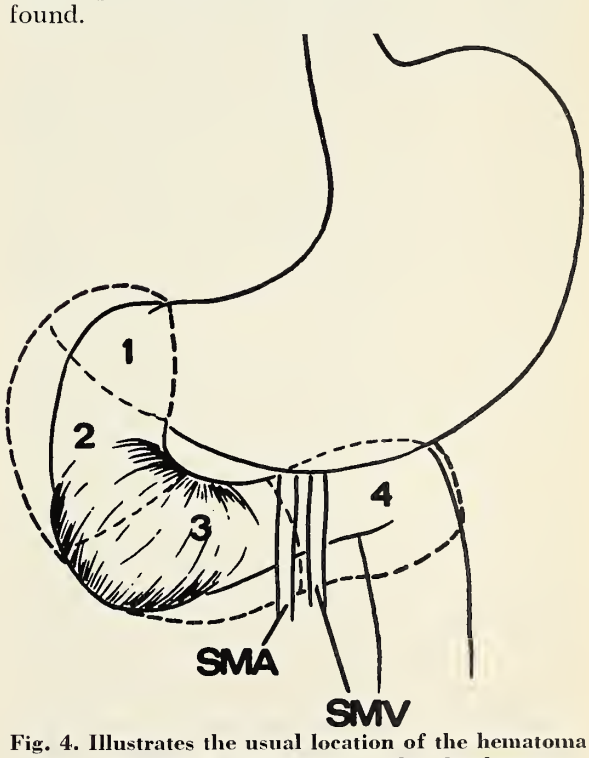


Fig. 4. Illustrates the usual location of the hematoma in the 2nd and 3rd portions of the duodenum as well as the possible extension (dotted line) from the pylorus into the proximal jejunum.

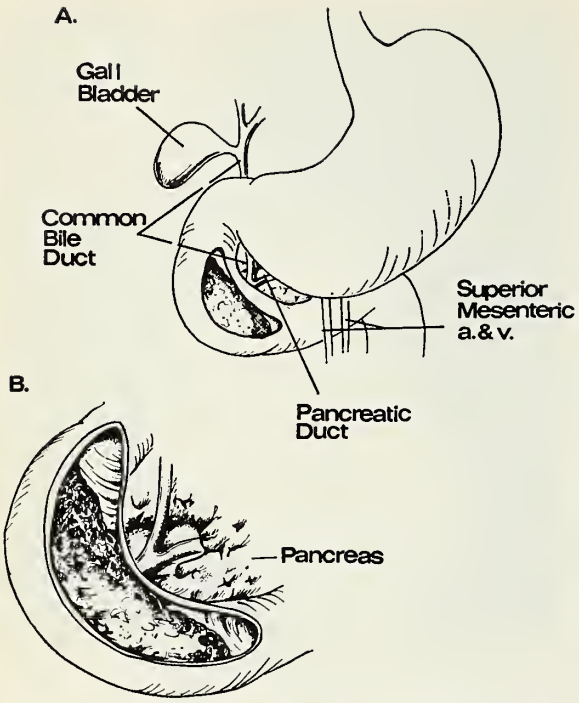


Fig. 5. Proximity of hematoma to ampulla of Vater. (b) detailed view showing obstruction of common bile duct and pancreatic duct.

Upright abdominal films showing a paucity of air distal to the duodenum strongly suggest the diagnosis of intramural hematoma of the duodenum (Fig. 1). The upper G.I. series is confirmatory showing gastric retention and irregularity of the duodenum (Fig. 2) or duodenal obstruction with a curved filling defect convex toward the stomach (Fig. 3). The obstruction may show as concentric rings outlined by contrast material as described by Felson, et al.[8] Barium is safe as a contrast media unless the child shows evidence of peritonitis in which event a water soluble media is preferred.

Opinion as to the treatment of choice is not unanimous. Advocates of non-operative treatment point out that with gastric decompression and I.V. alimentation the hematoma will absorb and the obstruction remit. Several authors report that with this approach 25% to 50% of their cases eventually required surgery for failure of the obstruction to be relieved.[9,10] The occasional occurrence of duodenal perforation, the frequency of associated injuries, as well as failures of nonoperative management, suggest that operative management is safer, more definitive and associated with a shorter convalescence.

Evacuation of the hematoma without violating the duodenal lumen usually is possible. A search for and correction of associated injuries is made at the same time. Recognition that the duodenum appears severely discolored, but is viable in almost all instances, will avoid ill advised radical surgery. We have not found the use of a feeding jejunostomy or trans-duodenal tube necessary. Alimentation has not been delayed more than five or seven days beyond surgery which interval is not difficult to manage with I.V. therapy.

Summary

- In a child epigastric pain and persistent vomiting as relatively isolated symptoms with or without a documented history of trauma should suggest the possibility of a duodenal hematoma.
- Delay between trauma and the onset of symptoms is characteristic, and may range from a few hours to several days.
- Upright films of the abdomen shows little or no air beyond the duodenum.
- Upper G.I. series confirms the diagnosis.
- A significant drop in hematocrit may occur but frank clinical shock suggests an associated visceral injury.
- Operative intervention is indicated in all except the occasional case in which medical care is sought late and the obstruction is obviously subsiding.
- Surgery is directed at evacuation of the hematoma combined with examination for and correction of any associated lesion. ◄

References

1. Freeark, R. J., et al: "Intramural Hematoma of the Duodenum," *Arch. Surg.*, 92:463, 1965.
2. Bailey, W. C. and Akers, D. R.: "Traumatic Intramural Hematoma of the Duodenum in Children," *Amer. J. of Surg.*, 110:695, 1965.
3. Moore, S. W. and Erlandson, M. E.: "Intramural Hematomas of the Duodenum," *Ann. Surg.*, 157:798, 1963.
4. Wiot, J. F., Weinstein, A. S. and Felson, B.: "Duodenal Hematoma Induced by Coumarin," *Amer. J. Roentgenol.*, 86:70, 1961.
5. Tobin, J. J., Schlong, H. A. and James, D. R.: "Intramural Hematoma of the Duodenum Associated with Peroral Small Bowel Biopsy," *JAMA*, 198:211, 1966.
6. Mullinger, M., et al: "Intramural Hematoma of the Duodenum: An Unusual Complication of Small Bowel Biopsy," *J. Pediatrics*, 78:323, 1971.
7. Parrish, R. A., Edmondson, H. T. and Moretz, W. H.: "Duodenal and Biliary Obstruction Secondary to Intramural Hematoma," *Amer. J. Surg.*, 108:428, 1964.
8. Felson, B., Levin, E. J.: "Intramural Hematoma of the Duodenum: A Diagnostic Roentgen Sign," *Radiology*, 63:823, 1954.
9. Kakos, G. S., Grosfeld, J. L. and Morse, T. S.: "Small Bowel Injuries in Children after Blunt Abdominal Trauma," *Ann. Surg.*, 174:238, 1971.
10. Jones, W. R., Hardin, W. J., Davis, J. T. and Hardy, J. D.: "Intramural Hematoma of the Duodenum," *Ann. Surg.*, 173:534, 1971.

Guest Editorial

The Role of the Social Worker in the Community Hospital

By Joseph F. Hinkamp, M.D./Evanston

Doctors always have been trained to assume total care of their patients. Modern medicine has altered this relationship. Now there are paramedical personnel who provide adjuvant patient care. Perhaps none is more vital than the social worker.

Many doctors are not acquainted with the competent performance of social service and how it has profoundly influenced medical practice. The reasons are insufficient time, indifferent attitude, and lack of information.

Because physicians are busy, they may not have the perspicacity to see that the social worker can assist them in the human relations of patient care. The uninformed may resent this assistance as an intrusion, but the discerning have recognized that it is the social worker with the doctor who makes the emotional committment to sympathy and personal concern.

Many medical educators have not taught an appreciation of the social sciences as they pertain to a patient. A lack of information may manifest itself as casual indifference. In fact, many hospital staffs have considered the social service department well meaning but mettlesome. This relationship has existed because of professional apathy. Medical educators can do much to restore native compassion and warmth for patients, by teaching the importance of communication.

History

The art of social service did not occur spontaneously. It seems to have evolved along with medicine as part of what it is. Although hospital almoners began early in the United States, it was not until 1905 at Massachusetts General Hospital that Dr. Richard Cobot established the first Social Service Department. After World War I, social service had become integrated into medical practice.

In 1929 the American College of Physicians and Surgeons in their report on *Hospital Standardization,* gave recognition to the importance of social work. As the nation became more prosperous and sophisticated there has been a shift in emphasis from the environmental to the psychologic aspect of social problems.

In the 1950's the civil rights movement gave further incentive to correct inequities in medical care. In 1960 the American Hospital Association and the National Association of Social Workers published the *Essentials of a Social Service Department in Hospitals and Related Institutions.*

The 1970's have awakened a new awareness in community health care problems which have intimately involved the social worker. The current interest in community medicine is reflected in the function of the Social Service Department of St. Francis Hospital Evanston. This department was organized in 1953 with one social worker, and at present there are 10 trained, experienced workers who serve private and clinic patients.

The Social Service Department always has been dedicated to assist the doctor with a resource of information and the patient with a source of security.

A cardinal tenet of the social service at St. Francis is that no plan is implemented for the patient without discussion with his physician. In 1970 a new social concept was conceived and implemented: the post Hospitalization Planning Service.

This plan was developed to insure that the medical and non-medical needs of the patient are identified before discharge. This idea is an extension of the concept that the hospital *with* the doctor had a social obligation to implement post hospital service.

The kinds of help a social worker can offer a physician's patient are, of course, determined by the patient's needs. That help may include arrangements for Meals-At-Home deliveries, and for services from the Visiting Nurse Association. It may consist of helping a couple plan for an infant with major anomalies; finding nurseries near the couple's home. Or, there is the elderly woman who is eager to return to her apartment rather than to enter a nursing home. This plan is possible only if community resources are mobil-

JOSEPH F. HINKAMP, M.D., is from the Department of Surgery at St. Francis Hospital, Evanston.

ized to provide the services she must have.

In this era of advanced technology society has become very depersonalized. In the hospital an atmosphere of detachment also may prevail. Sophisticated contemporary care provides for more and more medical personnel who come between the patient and his doctor.

Illness may have a strong impact on an individual and his social relationships. Motivation toward health and rehabilitation can be accelerated by meaningful people in the patient's environment. It is imperative that the doctor remember the key role that the social worker plays in the medical environment. It is that person who coordinates with the doctor the personalized care needed to restore the patient to a total individual.

Acknowledgement

My thanks to Mrs. Rose Pdolsky of the Social Service at St. Francis Hospital. ◄

Make An Offer

For some years now I have been telling my children that they have never had it so good and that they will look back to the days of the affluent society as something quite remarkable. To live in social class I in this country is such a privilege that I often feel very guilty, though human nature being what it is I cannot bring myself, any more than leading socialist politicians, to sell all I have and give to the poor. But I can state publicly that I think that I am adequately remunerated for the work that I do and and I can and do throw out all correspondence from the pressure groups seeking a larger slice of cake for consultants; yet again, human nature being what it is, I wonder if I would refuse were somebody to offer me more. (William Cowan: "Personal View." *Brit. Med. Journal* (Mar 9) 1974, pg. 451.

75 YEARS

Professional Protection

CONTINUOUSLY

Since 1899

THE MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

CHICAGO AREA OFFICE:

T. J. Pandak, J. C. Kunches, L. R. Gannon, and W. G. Prangle, Representatives

815 Commerce Drive, Suite 102, Oak Brook, Illinois 60521 (312) 325-7314

SPRINGFIELD OFFICE: W. J. Nattermann, Representative

426½ South Fifth Street, Springfield 62701 (217) 544-2251

CNA INSURANCE
CONTINENTAL CASUALTY Co.

Proudly presents a 4 Phase Health Insurance Plan for

...PHYSICIANS AND SURGEONS

Select any one or all of the following four phase plans;

(1) Income Protection This plan will pay a salary in the event of illness or accident; with limits up to $3,500.00 per month.

(2) Overhead Expense This plan will pay the expenses of your business in the event insured is sick or hurt. Premium is TAX DEDUCTIBLE; IRS ruling No. 55-264 I.R.B. 1955—19,8.

(3) Hospital Indemnity ... Pays to the insured or members of his family while hospital confined, with limits up to $100.00 per day.

(4) Major Medical Pays the major part of hospital and medical bills, with several deductible features to select from.

Highlights of this outstanding Health Plan are:

—MOST RISKS WILL BE ACCEPTED . . . EVEN APPLICANTS WITH HISTORIES OF DIABETES, HEART, CANCER, AND MANY OTHER CHRONIC ILLNESSES . . .
—BENEFITS ARE FEDERAL TAX FREE UNDER THE INCOME PROTECTION PLAN . . .
—NO REDUCTION IN BENEFITS AT ANY AGE UNDER THE INCOME, OVERHEAD EXPENSE, OR HOSPITAL CASH PLANS . . .
—UNDERWRITTEN BY CNA/CONTINENTAL CASUALTY, AN INNOVATOR AND PIONEER IN HEALTH INSURANCE SINCE 1897.

We strongly urge you to participate in this outstanding program of health protection. For further information without any obligation call

679-1565

CNA Insurance

Great Lakes Health Insurance Agency

or complete the enclosed information form.

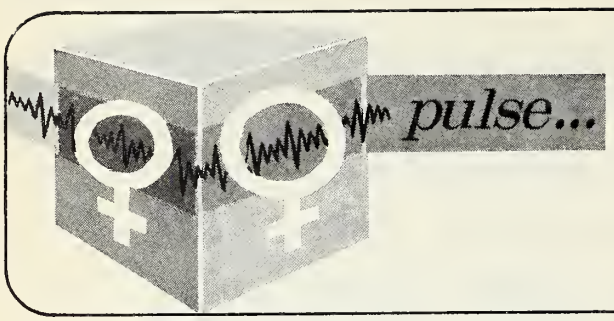
Gentlemen: Please give me information regarding your Health Insurance Program. I understand I am free of any obligations.

Name: _____

Address _____

Home telephone _____ Office telephone _____

CNA Insurance
Great Lakes Health Insurance Agency
Suite #221 Old Orchard Professional Bldg.
Skokie, Illinois 60076



pulse... of the doctor's wife

Mrs. Harold Keegan, Editor

County Project

THRESHOLD!

What is it?

Mrs. Robert Hartman, Past President WA/ISMS, spoke of THRESHOLD in her annual report to the State Convention. You saw a display on it at the annual meeting. THRESHOLD is a Drug Rehabilitation Center in Kankakee with live-in facilities for young polydrug users, and out-patient treatment for heroin users. All persons who live at THRESHOLD are there voluntarily. Some are referred from hospitals or psychiatric agencies or the police. But they must be there because they *want* to be. The hope is to have the person off the drugs by six months or a year, but they are kept in treatment as long as necessary.



THRESHOLD has been the WA/Kankakee County Medical Society's special project for the last two years. The Auxiliary's assistance to THRESHOLD began in the fall of 1972. The Kankakee County Medical Society members asked their wives to help supply THRESHOLD with household furnishings. A committee composed of Mrs. Herbert Swartz, Chairman, Mrs. Reinhold Schuller, Mrs. Stephen Sniderman, Mrs. Donald Parkhurst, Mrs. Armando Arocha, and Mrs. Harold Keegan set to work. Through a "THRESHOLD" shower, coffee and word of mouth, household furnishings and monies were gathered.

Who is it?

The program began accepting young drug users. Auxiliary members were informed that the household was growing and needed recreation; so the Auxiliary provided YMCA memberships.

Recently THRESHOLD celebrated an open house and the Auxiliary provided the refreshments. Now, THRESHOLD has become a community project with support of other organizations.

In retrospect, it seems that the Auxiliary lent moral support and stability at a time when it was most needed by all. The reward from the project seemed to go both ways. THRESHOLD received much needed furnishings and support, and the Auxiliary members learned about drugs, and their effect on the youth of the community.

You will be hearing more about THRESHOLD through an article in the September is-



These displays on THRESHOLD were prepared by Mrs. J. B. Pinski, Past President, WA/KCMS, for the County Report at the State Convention.

sue of *M.D.'s WIFE* and Mrs. Hartman's report to the WA/AMA convention.

Thus we find that the Auxiliary can be a powerful and helpful force in enhancing health to a community.

Congratulations, Kankakee County!



Jean Hodges

Salute to Jean Hodges, WA/ISMS Treasurer

Auxilians, I introduce to you Mrs. William T. (Jean) Hodges, Kankakee. An active member of the Kankakee County and Illinois State Medical Society Auxiliaries, she has served in many capacities. On the county level, she has been the Health Careers Chairman; AMA/ERF Chairman, Parliamentarian, Director and President. She now begins her fourth year as the Treasurer of the WA/ISMS, which is a busy, time consuming job.

Jean finds time to be active in her community. She works with the missionary society of her church, the "Friends of Music" community concerts; the Art League, Tuesday book review; and the Woman's Club.

A busy wife and Mother, Jean has two sons, Tim, a pre-med college freshman, and Rob, a junior at Eastridge High School. On occasion she assists her husband, Bill, a Diplomate in the Academy of Family Practice, in his office. Before her marriage, she worked as an operating room nurse supervisor and as a private scrub nurse.

Even with her active schedule she finds time to collect cook books, of which she has over 100, paints, collects and refinishes antique furniture.

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
360 No. Michigan Ave. • Chicago, IL 60601 • (312) 782-1654

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

JULY

Alcoholism

POST-GRADUATE COURSE ON ALCOHOLISM
For: All physicians. One-day workshop & luncheon, July 31, 1974, American Hospital Assn., 840 N. Lake Shore Dr., Chicago. **Hrs. of Instr.:** 7. **CME Credit:** AMA Category 1. **Fee:** $35. **Reg. Deadline:** July 21, 1974. **Sponsor, contact:** James W. West, M.D., Med. Dir., Central States Addictions Institute, 122 S. Desplaines, Chicago, IL 60606. **Co-sponsor:** AMA Dept. of Mental Health.

Family Medicine

FAMILY PRACTICE REVIEW
For: Family Physicians. Symposium, July 9-11, 1974, Stouffer's Indianapolis Inn, Indianapolis. **Hrs. of Instr.:** 26½. **CME Credit:** AAFP, AMA Category 1. **Fee:** $75. **Sponsor, contact:** Mr. John Roscoe, Program Coord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

General Interest

PAS & MAP TUTORIAL SESSION
For: Physicians, Hosp. Admin., Allied Health. July 10-11, 1974, Ann Arbor, Mich. **Hrs. of Instr.:** 12. **CME Credit:** AMA Category 1. **Fee:** $110 (1-4 persons, if at least 2 physicians). **Sponsor, contact:** Commission on Professional & Hosp. Activities, 1968 Green Rd., Ann Arbor, MI 48105.

SUMMER PROGRAM ON HUMAN SEXUALITY
For: All physicians. 11-day workshop, July 14-25, 1974, Bloomington, Ind. **Hrs. of Instr.:** 90. **CME Credit:** AMA Category 1. **Fee:** $250 + housing & meals. **Reg. Limit:** 125. **Sponsor, contact:** Institute for Sex Research, Indiana Univ., 416 Morrison Hall, Bloomington, IN 47401.

Your Ideas, Please

If there's a continuing education course or other learning service not now available that you'd find helpful—please write us about it, or jot a note on your prescription pad. Periodically, we'll tabulate those ideas and transmit the information to appropriate CME sources.

Regretfully, available staff does not permit responses to individual suggestions.

Obstetrics/Gynecology

GYNECOLOGICAL LAPAROSCOPY
For: Board certified or eligible specialists. 5-day course, July 15-19, 1974, Chicago. **Hrs. of Instr.:** 15. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 8. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

VAGINAL APPROACH TO PELVIC SURGERY
For: Board certified or eligible specialists. 6-day course, July 15-20, 1974, Chicago. **Hrs. of Instr.:** 20. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 16. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Surgery

FIBEROPTIC COLONOSCOPY
For: All physicians. 3-day course, July 10-12, 1974, Chicago. **Hrs. of Instr.:** 21. **CME Credit:** AMA Category 1. **Fee:** $125. **Reg. Limit:** 10. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

UPPER MIDWEST REVIEW OF GASTROENTEROLOGY
For: Family Physicians, General Surgeons, Proctologists, Gastroenterologists. 1½-day seminar, July 13-14, 1974, Pfister Hotel, Milwaukee, Wis. **Hrs. of Instr.:** 10. **CME Credit:** AAFP. **Fee:** $125. **Reg. Limit:** 125. **Sponsor, contact:** A. T. Finnegan, Ofc. of Cont. Educ., The Medical College of Wisconsin, 561 N. 15th St., Milwaukee, WI 53233.

ADVANCED PERIPHERAL VASCULAR SURGERY
For: Specialists. 5-day course, July 15-19, 1974, Chicago. **Hrs. of Instr.:** 40. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 40. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY
For: Specialists. 3-day course, July 31-Aug. 2, 1974, Chicago. **Hrs. of Instr.:** 19½. **CME Credit:** AMA Category 1. **Fee:** $150. **Reg. Limit:** 10. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

AUGUST

Emergency Care

EMERGENCY MEDICAL CARE
For: All physicians. August 12-16, 1974; Wisconsin Cntr., Madison, Wis. **Sponsor, contact:** Univ. of Wisconsin, Dept. of Continuing Med. Educ., 610 N. Walnut St., Madison, WI 53706.

Family Medicine

SPECIALTY REVIEW COURSE FOR FAMILY MEDICINE
For: Family Physicians. 10½-day course, August 12-23, 1974, Chicago. **Hrs. of Instr.:** 98. **CME Credit:** AMA Category 1. **Fee:** $300. **Reg. Limit:** 150. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

General Interest

PAS & MAP TUTORIAL SESSION
For: Physicians, Hosp. Admin., Allied Health. August 7-8, 1974, Ann Arbor, Mich. **Hrs. of Instr.:** 12. **CME Credit:** AMA Category 1. **Fee:** $110 (1-4 persons, if at least 2 physicians). **Reg. Limit:** 75. **Sponsor, contact:** Commission on Professional & Hosp. Activities, 1968 Green Rd., Ann Arbor, MI 48105.

Orthopedics

SPECIALTY REVIEW COURSE IN ORTHOPAEDICS
For: Specialists. 6½-day course, August 25-31, 1974, Chicago. **Hrs. of Instr.:** 60. **CME Credit:** AMA Category 1. **Fee:** $200. **Reg. Limit:** 60. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Psychiatry

WINNEBAGO SYMPOSIUM FOR GENERAL PRACTITIONERS
For: Family Physicians. August 22, 1974, The Pioneer Inn, Oshkosh, Wis. **Hrs. of Instr.:** 6. **CME Credit:** AMA Category 1. **Fee:** $15. **Reg. Limit:** 60. **Sponsor, contact:** Winnebago State Hospital, Box H, Winnebago, WI 54985.

Sports Medicine

SPORTS MEDICINE
For: Family Physicians, Allied Health. One-day workshop, August 28, 1974, Indianapolis. **Hrs. of Instr.:** 7. **CME Credit:** AMA Category 1. **Sponsor, contact:** Mr. John Roscoe, Program Co-ord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

Clinical Preceptorships—Indiana University

These experiences are designed for the physician who would like an in-depth look at or experience in a particular medical or surgical field. Each program is designed *individually* for the contracting physician to meet his particular needs. The program can be set up for any length of time that fits the need.

For further information, contact:
Steven C. Beering, M.D.
Associate Dean
Indiana University School of Medicine
1100 W. Michigan St.
Indianapolis, Ind. 46202

SEPTEMBER

Alcoholism

ALCOHOLISM
For: All Physicians, Allied Health. Weekly medical education seminar, Sept. 24, 1974, 11:30 AM, Memorial Hospital of DuPage County, Elmhurst, Ill. **Speaker:** Herbert Neuhaus, M.D., Dept. of Public Health Hosp., Chicago. **Hrs. of Instr.:** 1. **CME Credit:** AMA Category 1. **Sponsor, contact:** John H. Huss, M.D., DME, Memorial Hospital of DuPage County, Avon Rd. & Schiller St., Elmhurst, IL 60126.

Anesthesiology

CLINICAL ANESTHESIA PRACTICE—COURSE I
For: All Physicians. 1-month course, Sept. 30-Oct. 29, 1974, Chicago. **Hrs. of Instr.:** 176 approx. **CME Credit:** AMA Category 1. **Fee:** $400. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Cardiology

INTERMEDIATE CARDIOLOGY
For: All Physicians. 4½-day course, Sept. 23-27, 1974, Chicago. **Hrs. of Instr.:** 32 approx. **CME Credit:** AMA Category 1. **Fee:** $175. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

ECHOCARDIOGRAPHY WORKSHOP
For: Specialists. 4-day course, Sept. 30-Oct. 3, 1974, Indianapolis. **Hrs. of Instr.:** 28. **CME Credit:** AMA Category 1. **Reg. Limit:** 50. **Sponsor, contact:** Mr. John Roscoe, Program Co-ord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

Gastroenterology

UPPER GASTROINTESTINAL ENDOSCOPY
For: Specialists. 2-week course, Sept. 9-20, 1974, Chicago. **Hrs. of Instr.:** 40 approx. **CME Credit:** AMA Category 1. **Fee:** $350. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

FIBEROPTIC COLONOSCOPY
For: All Physicians. 3-day course, Sept. 11-13, 1974, Chicago. **Hrs. of Instr.:** 21 approx. **CME Credit:** AMA Category 1. **Fee:** $250. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY
For: Specialists. 3-day course, Sept. 16-18, 1974, Chicago. **Hrs. of Instr.:** 20 approx. **CME Credit:** AMA Category 1. **Fee:** $250. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Internal Medicine

REVIEW COURSE IN RHEUMATOLOGY
For: Family Physicians. 1-week course, Sept. 9-13, 1974, Chicago. **Hrs. of Instr.:** 35 approx. **CME Credit:** AMA Category 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

REVIEW COURSE IN PULMONARY
For: Family Physicians. 1-week course, Sept. 9-13, 1974, Chicago. **Hrs. of Instr.:** 35 approx. **CME Credit:** AMA Category 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

RECENT CONCEPTS IN DIABETIC MANAGEMENT
For: All Physicians, Allied Health. Weekly medical education seminar, Sept. 10, 1974, 11:30 AM, Memorial Hospital of DuPage County, Elmhurst, Ill. **Speaker:** Ann M. Lawrence, M.D., Univ. of Chicago. **Hrs. of Instr.:** 1. **CME Credit:** AMA Category 1. **Sponsor, contact:** John H. Huss, M.D., DME, Memorial Hospital of DuPage County, Avon Rd. & Schiller St., Elmhurst, IL 60126.

ENDOCRINOLOGY
For: Internists. 3-day course, Sept. 11-13, 1974, Hilton Hotel, Indianapolis. **Hrs. of Instr.:** 18. **CME Credit:** AMA Category 1. **Sponsor, contact:** American College of Physicians, 4200 Pine St., Philadelphia, PA 19104.

REVIEW COURSE IN HEMATOLOGY
For: Family Physicians. 1-week course, Sept. 30-Oct. 4, 1974, Chicago. **Hrs. of Instr.:** 35 approx. **CME Credit:** AMA Category 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

REVIEW COURSE IN INFECTIOUS DISEASES
For: Family Physicians. 1-week course, Sept. 30-Oct. 4, 1974, Chicago. **Hrs. of Instr.:** 35 approx. **CME Credit:** AMA Category 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

REVIEW COURSE IN NEPHROLOGY
For: Family Physicians. 1-week course, Sept. 30-Oct. 4, 1974, Chicago. **Hrs. of Instr.:** 35 approx. **CME Credit:** AMA Category 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Postgraduate Traineeships

University of Wisconsin Medical Center offers a postgraduate experience in *Gastrointestinal Endoscopy* for individual physicians, at individually-arranged dates. The program lasts 10 days, and offers 80 hours of instruction; fee is $350.

For further information, contact:
Dept. of Medicine
University of Wisconsin
Medical Center
1300 University Ave.
Madison, WI 53706

An *Oncology Traineeship* is available at the University of Iowa College of Medicine. Dates are individually arranged; the program lasts 30 days, with 160 hours of instruction.

For more information, write:
Office of Cont. Med. Educ.
University of Iowa College of Medicine
Iowa City, Iowa 52242

Neurology

SPECIALTY REVIEW IN NEUROLOGY—PART II, CLINICAL
For: All Physicians. 1-week course, Sept. 9-13, 1974, Chicago. **Hrs. of Instr.:** 44 approx. **CME Credit:** AMA Category 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Obstetrics/Gynecology

BASIC GYNECOLOGY
For: All Physicians. 1-week course, Sept. 16-20, 1974, Chicago. **Hrs. of Instr.:** 35 approx. **CME Credit:** AMA Category 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

GYNECOLOGICAL LAPAROSCOPY
For: Specialists. 1-week course, Sept. 23-27, 1974, Chicago. **Hrs. of Instr.:** 15 approx. **CME Credit:** AMA Category 1. **Fee:** $250. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Ophthalmology

OPHTHALMOLOGY
For: All Physicians. 2-day seminar, Sept. 6-7, 1974, Wisconsin Center, Madison, Wis. **Sponsor, contact:** Dept. of Cont. Med. Educ., Univ. of Wisconsin Med. Sch., 610 Walnut St., Madison, WI 53706.

Pediatrics

COMPREHENSIVE CHILDHOOD TRAUMA SYMPOSIUM
For: All Physicians. 2-day symposium, Sept. 11-12, 1974, Stouffer's Inn, Indianapolis. **Hrs. of Instr.:** 14. **CME Credit:** AMA Category 1. **Sponsor, contact:** Mr. John Roscoe, Program Co-ord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

PROBLEMS IN PEDIATRIC UROLOGY MANAGEMENT
For: All Physicians. One-day workshop, Sept. 25, 1974, Indianapolis. **Hrs. of Instr.:** 7. **CME Credit:** AMA Category 1. **Sponsor, contact:** Mr. John Roscoe, Program Co-ord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

Radiology

GAMMA SCINTILLATION CAMERA WORKSHOP
For: Specialists. 3-day workshop, Sept. 5-7, 1974, Indianapolis. **Hrs. of Instr.:** 21. **CME Credit:** AMA Category 1. **Reg. Limit:** 30. **Sponsor, contact:** Mr. John Roscoe, Program Co-ord., Indiana Univ. Sch. of Med., 1100 W. Michigan St., Indianapolis, IN 46202.

Surgery

REVIEW COURSE IN PLASTIC SURGERY
For: Plastic Surgeons. 3-day lecture series, Sept. 3-5, 1974, McGaw Med. Cntr., Northwestern Univ., Chicago. **Hrs. of Instr.:** 18½. **Fee:** $200. **Reg. Deadline:** July 31, 1974. **Sponsor:** Dept. of Surgery, Northwestern Univ. Med. Sch. **Contact:** D. A. Kernahan, M.D., Childrens Memorial Hospital, 2300 Childrens Plaza, Chicago, IL 60614.

MANAGEMENT OF COMPLICATIONS IN SURGERY
For: All Physicians. 4-day course, Sept. 16-19, 1974, Chicago. **Hrs. of Instr.:** 28 approx. **CME Credit:** AMA Category 1. **Fee:** $175. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

FLUID & ELECTROLYTE MANAGEMENT
For: All Physicians. 1-week course, Sept. 23-27, 1974, Chicago. **Hrs. of Inst.:** 30 approx. **CME Credit:** AMA Category 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

BRONCHOSCOPY
For: Specialists. 1-week course, Sept. 23-27, 1974, Chicago. **Hrs. of Inst.:** 20 approx. **CME Credit:** AMA Category 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

DISEASES OF ESOPHAGUS, STOMACH & DUODENUM
For: All Physicians. 3-day course, Sept. 26-28, 1974, Chicago. **Hrs. of Instr.:** 20 approx. **CME Credit:** AMA Category 1. **Fee:** $125. **Sponsor, contact:** Cook County Grad. Sch. of Med. 707 S. Wood St., Chicago, IL 60612.

SPECIALTY REVIEW IN GEN. SURGERY—PART I
For: Surgeons. 2-week course, Sept. 30-Oct. 11, 1974, Chicago. **Hrs. of Instr.:** 94 approx. **CME Credit:** AMA Category 1. **Fee:** $350. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago, IL 60612.

Sports Medicine Your Bag?

If so, you'll be interested in *A.I.D.—Athletics . . . Injury & Disease*—published quarterly by the Edgar County Medical Society and ISMS. Planned primarily for coaches — *i.e.*, non-MDs — you'll find it helpful if you work with your local school team, Little League, or similar athletic programs. You might also wish to suggest its usefulness to local coaches and team sponsors.

To receive *A.I.D.*, write:
J.M. Ingalls, M.D.
502 Shaw Avenue
Paris, IL 61944



A New Voice for Housestaff

By Michael Hughey, M.D./Evanston

The "Housestaff News" is a new feature in the IMJ designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

Illinois housestaff physicians will have a new voice in organized medicine next year with the appointment of a housestaff delegate and alternate to the ISMS House of Delegates. Resolution 74A-45, passed at the 1974 ISMS convention, creates these new positions in the House of Delegates. Through the intern/resident delegate, housestaff views will be better represented to the ISMS at future meetings. Medical students have had their own delegate and alternate for the past five years.

This action taken by ISMS is part of a sustained effort to involve more housestaff physicians in the affairs of the State Society. At the recent convention in Chicago, three other resolutions dealing with housestaff physicians were passed by the House of Delegates. Among them was a resolution lowering housestaff dues for ISMS from $10 to $5 a year. In addition, the resolution asked the AMA and local county societies to lower their dues for housestaff. Currently, several county societies do not charge housestaff physicians any dues, in deference to their training status. It is hoped that through these reductions in dues, housestaff physicians across Illinois will be encouraged to join and participate in organized medicine.

Even without the reduction in dues, a tremendous growth in housestaff membership in ISMS has occurred in the past several years. Since 1968, housestaff membership has risen more than two-fold, from 196 in 1968 to 480 in 1973. The preliminary figures for 1974 predict even greater housestaff membership by the end of the year. In 1973, the first year membership was available to interns, a total of 49 interns joined ISMS. It is expected that this figure will continue to grow with the recent reduction in dues.

Probably the most important resolution passed at the recent ISMS convention deals with the continued funding for medical student and housestaff projects. The Advisory Committee to Medical Students and Physicians in Training has been active in the last two years developing a number of programs designed to benefit housestaff physicians. With the additional funding, these programs will continue. The Advisory Committee's programs listed in Resolution 74A-40, include:

1. A follow-up study of the MECO project participants, to determine the effect of the project on career goals.
2. The placement of housestaff physicians and medical students on many of ISMS's councils and committees.
3. Development of a publicity and membership campaign aimed at housestaff and medical students.
4. Financial assistance to housestaff and medical students attending AMA conventions.
5. Preliminary work on compiling and publishing a handbook of electives for medical students in Illinois.
6. Assistance in forming intern-resident organizations throughout the state.
7. Development of "local issue conferences" involving both housestaff and medical students.
8. Assistance to local clinics and other projects involving housestaff in Illinois.

The Advisory Committee has been particularly successful in placing housestaff physicians on a number of ISMS councils and committees. These housestaff physicians have made significant contributions to their councils and are to be commended for their efforts. The six councils and their housestaff representatives for the past year are:

Council on Economics and Peer Review, Ron Staubly, M.D.

Council on Education and Manpower, Bruce Fagel, M.D., and David Spindel, M.D. *(alternate)*

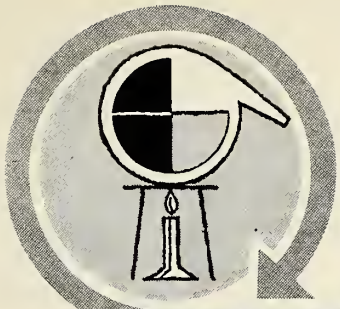
Council on Environmental and Community Health, Marc Rose, M.D.

Medical/Legal Council, Cheng H. Hsu, M.D., and Sunt Wanasukaput, M.D. *(alternate)*

Council on Mental Health and Addiction, Richard Dudley, M.D., Barry Storter, M.D., *(alternate)* and Stearly Alling, M.D. *(alternate)*

Council on Social and Medical Services, Carl C. Bell, M.D.

Any housestaff physician interested in participating in any of the ISMS councils is encouraged to contact the ISMS office. In addition, all housestaff physicians involved in extra-curricular projects needing support, moral or material, should contact the ISMS Advisory Committee to Medical Students and Physicians in Training. Although not all projects would qualify for the Advisory Committee's assistance, the Advisory Committee is particularly interested in helping wherever it can. ◄



new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

AMOXIL — Semisynthetic Penicillin — Rx

Manufacturer: Beecham-Massengill

LAROCIN

Manufacturer: Roche Laboratories, Nutley, N.J.
Nonproprietary Name: Amoxicillin
Indications: Susceptible infections caused by Gram-negative and Gram-positive organisms
Warnings: Do not use in patients hypersensitive to penicillins or cephalosporins
Dosage: See package insert
Supplied: Capsules, 250 and 500 mg. as trihydrate
Oral Suspension, 5cc./125 and 250 mg. as trihydrate
Pediatric Drops, cc/50 mg. as trihydrate

CEFADYL — Broad and Medium Spectrum Antibiotic — Rx

Manufacturer: Bristol Laboratories, Syracuse, New York
Nonproprietary Name: Cephapirin sodium
Indications: Infections caused by susceptible organisms in skin, soft tissue and the respiratory tract.
Contraindications: Hypersensitivity
Warnings and Precautions: See package insert
Dosage: Adults, 500 mg. or 1 Gm. every 4 to 6 hrs. i.v. or i.m.
Children, depending on age
Supplied: Vial, eq. to 1 Gm. cephapirin

EMETE-CON — Injectable antianuseant — Rx

Manufacturer: Roerig, Div. of Pfizer, Inc. New York, N.Y.
Nonproprietary Name: Benzquinamide
Indications: Prevention and treatment of nausea and vomiting associated with anesthesia and surgery.
Contraindications: Hypersensitivity to the drug
Warnings and Precautions: See package insert
Dosage: i.v. or i.m.; for details see package insert
Supplied: Vials, 50 mg.

MONISTAT Cream — Vaginal Antiinfective — Rx

Manufacturer: Ortho Pharmaceutical Corp. Raritan, N.J.
Nonproprietary Name: Miconazole nitrate
Indications: Vulvovaginal candidiasis (Diagnosis should be confirmed)
Contraindications: Hypersensitivity
Administration: Once daily at bedtime for 14 days
Supplied: Tubes, 3 ozs., cream 2%

ZAROXOLYN — Diuretic and Antihypertensive — Rx

Manufacturer: Pennwalt Prescription Products
Nonproprietary Name: Metolazone
Indications: Edema in congéstive heart failure and renal diseases; mild to moderate hypertension
Contraindications: Anuria, hepatic coma and known allergy to the drug.
Warnings and Precautions: Follow package insert
Dosage: Cardiac failure: 5-10 mg. once daily
Renal disease: 5-20 ng. once daily
Hypertension: 2.5-5 mg. once daily
Adjust to patient's response
Supplied: Tablets, 2.5, 5 and 10 mg.

DUPLICATE SINGLE DRUGS

DIUCARDIN — Antihypertensive — Rx

Manufacturer:	Ayerst Laboratories New York, N.Y.
Nonproprietary Name:	Hydroflumethiazide
Indications:	Edema associated with congestive heart failure, hepatic cirrhosis and corticoid and estrogen therapy. Mild and moderate hypertension.
Contraindications:	Anuria oliguria and hypersensitivity to the drug and sulfonamides
Precautions:	Those usual for thiazide douretics
Dosage:	50-100 mg daily
Supplied:	Tablets, 50 mg.

CEN-APAP — Mild Analgesic — o.t.c.

Manufacturer:	Central Pharmacal Co. Seymour ,Ind.
Nonproprietary Name:	Acetaminophen
Indications:	Temporary relief of minor pain and fever
Caution:	Do not use for more than 10 days
Dosage:	Children 6-12 yrs, 2 tsp, t.i.d. Children 3-6 yrs, 1 tsp, t.i.d.
Supplied:	Bottles 4 ozs, 120 mg. (alcohol 10%)

NIAC — Vitamin — Rx

Manufacturer:	Cole Pharmacal Company, Inc. St. Louis, Mo.
Nonproprietary Name:	Niacin (Nicotinic acid)
Indications:	Conditions with deficient circulation
Contraindications:	Severe hypotension and arterial bleeding
Precautions:	See package insert
Dosage:	One capsule every 12 hours.
Supplied:	Slow release capsules, 300 mg.

THIURETIC — Diuretic and Antihypertensive — Rx

Manufacturer:	Parke, Davis and Company Detroit, Mich.
Nonproprietary Name:	Hydrochlorothiazide
Indications:	Edema associated with congestive heart failure and hepatic cirrhosis; mild to moderate hypertension.
Contraindications:	Anuria, oliguria and hypersensitivity to the drug and sulfonamides
Precautions:	Those usual for thiazide diuretics
Dosage:	75-100 mg daily
Supplied:	Tablets, 25 and 50 mg.

PRED Mild — Corticosteroid for the Eye — Rx

Manufacturer:	Allergan Pharmaceuticals Irvine, Cal.
Nonproprietary Name:	Prednisolone Acetate
Indications:	Mild to moderate non-infectious allergic and inflammatory disorders of the lid, conjunctiva, cornea and sclera.
Contraindications:	Those usual for corticosteroids
Dosage:	1-2 drops, b.i.d. to q.i.d.
Supplied:	Suspension, 0.12%

COMBINATION PRODUCTS

MYADEC Tablets — Vitamin Mineral Product — o.t.c.

Manufacturer:	Parke-Davis & Co. Detroit, Mich.
Composition:	9 Vitamins 6 Minerals
Indications:	Certain Vitamin deficiencies
Dosage:	One Tablet daily
Supplied:	Tablets

NEW DOSAGE FORMS

POVAN Filmseal — Anthelmintic — Rx

Manufacturer:	Parke, Davis & Co. Detroit, Mich.
Nonproprietary Name:	Pyrvinium Pamoate
Indications:	Enterobiasis
Contraindications:	Patients sensitive to aspirin
Dosage:	Children and adults with pinworm infections: Single dose 5 mg/kg.
Supplied:	Filmseal Tablets, 50 mg.

KAOCHLOR S-F — Mineral Supplement — Rx

Manufacturer:	Warren-Teed Pharmaceuticals, Inc., Columbus, Ohio
Nonproprietary Name:	Potassium Chloride
Indications:	Hypokalemic conditions
Contraindications:	Those usual for potassium therapy
Dosage:	One tablespoonful (15 cc) in three ozs of water 2 to 4 times daily
Supplied:	Liquid, 10% ◄

EKG of the Month

(Continued from page 525)

Answers: *1. C. 2. C,D*

The lead I, II, III rhythm strip shows a slight sinus arrhythmia with dropped sinus beats following the third and the eighth QRS. There is a gradual prolongation of the PR interval leading up to the dropped sinus beat. This is AV Wenckebach second degree block. It is a common manifestation of digitalis intoxication. Therefore, stopping digitalis and checking the serum electrolytes, especially potassium would be important. If the overall ventricular rate is not too slow, no further measures are needed. ◄

Accumulative Index

Volume 145

January - June, 1974

January	**Page 1-84**	**April**	**293-366**
February	**85-160**	**May**	**377-456**
March	**161-292**	**June**	**457-548**

A

Abdominal Wall Abscess in an Infant, R. J. Romanus, 515

Abel, Stuart, *jt. author,* Repeat Cesarean Section in a Low Socio Economic Population (J. Dickstein, M. Brown and J. Zackler) 118

Abstracts of Board Actions, 366, 396

Abstracts of House of Delegates, 427

Adult Endocardial Fibroelastosis Following Electric Shock (E. C. Naguit and H. Dexheimer) 115

Against Medical Advice, see **EDITORIALS**

Albrecht, R. F., *jt. author,* Cardiovascular Collapse During Gynecological Laparoscopy (A. D. Ivankovich, B. Zahed and R. F. Bonnet) 58

Aneurysm of the Gastroduodenal Artery: A Cause of Gastrointestinal Bleeding (J. E. Weese) 40

Angiosarcoma of the Liver (T. Lee and A. G. Lawrence) 324

B

Barthelemy, Carl R., *jt. author,* The Non-Visualizing Gallbladder (J. L. Gibbs) 408

Battle, W. Stuart, *jt. author,* Hemofiltration For Schistosomiasis Jajonicum (L. Nyhus and C. T. Bombeck) 317

Beal, John M., Editor, see **SURGICAL GRAND ROUNDS,** 68, 274, 338, 410, 526

Berkley, Kelly M., Meckel's Diverticulum, 125

Betts, Henry B., *jt. autor,* Speech Therapy for the Mildly Dysphasic Patient: When is it Indicated, (J. S. Huret) 512

Bilos, Z. J., *jt. author,* Forearm Replantation, A Case Report of a Two Year Follow Up, (H. Labinsky, H. Khazie) 315

Bombeck, C. Thomas, *jt. author,* Hemofiltration For Schistosomiasis Jajonicum (W. S. Battle and L. M. Nyhus) 317

Bonnet, R. F., *jt. author,* Cardiovascular Collapse During Gynecological Laporoscopy (A. D. Ivankovich, R. F. Albrecht and B. Zahed) 58

Boswell, Dee C., *jt. author,* Probable 16 Year Course in Patient with Thrombotic Thrombocytopenic Purpura (G. Sierra) 29

Brown, Murray, *jt. author,* Repeat Cesarean Section in a Low Socio Economic Population (J. Dickstein, J. Zackler and S. Abel) 118

Brown Recluse Spider Bite, Increasing Incidents in Northern Illinois, (R. Simmons and J. Curtin) 43

Brown, Rowine Hayes, **(PEDIATRIC PERPLEXITIES)** Acute Yellow Phosphorus) Rat Poisoning, 128

Burns, Treatment of, see J. G. Raffensperger

Bush, Irving M., *jt. author,* Neuromuscular Dysfunctions of the External Urinary Sphincter, (N. Sadoughi) 497

C

Cardiovascular Collapse During Gynecologic Laporscopy (A. D. Ivankovich, R. F. Bonnet, R. Albrecht, and B. Zahed) 58

Cecal Volvulus, see **SURGICAL GRAND ROUNDS**

Cesarean, see J. S. Dickstein

Chiropractors, see "Snap, Crackle and Pop!" **(SPECIAL ARTICLE)**

Clinical Variations of Cystic Fibrosis, D. G. Cunningham, 493

CLINICS FOR CRIPPLED CHILDREN, 26, 108, 180, 312, 402, 000

Common Problems in High Risk Nurseries (S. Pildes) 47

CONTINUNING MEDICAL EDUCATION, ISMS GUIDE TO, 74, 148, 272, 364, 448, 534

Control of Habit Forming Drugs **(SPECIAL ARTICLE)** 348

Convention, **SPECIAL ISSUE,** 193

Convention Summary: Abstracts of Board Actions, 396; 1974-75 Officers and Trustees, 420; Highlights of Convention, 421; Summary of House of Delegates Action, 427; Action on Resolutions, 431

Cunningham, Daniel G., Clinical Variations of Cystic Fibrosis, 493

Curling, the Psychological Value of the Sport (T. N. Davis) 37

Curtin, John W., *jt. author,* Brown Recluse Spider Bite, Increasing Incidents in North Illinois (R. Simmons) 43

Cushing's Forceps, Rediscovery of, see H. A. Johnson

Cystic Fibrosis, see D. G. Cunningham

D

Davis, Thomas N., The Psychological Value of the Sport, Curling, 37

Dayhem, M. K., Electrical Alternans, Case Report and Comments on its Mechanism and Diagnostic Significance (S. Kumar) 500

Death of Moonlighting, **ILLINOIS HOUSESTAFF NEWS** (M. Hughey and K. M. Tan) 418

DeHaen, Paul, **NEW PHARMACEUTICAL SPECIALTIES,** 144, 190, 412, 537

Dexheimer, Herbert, *jt. author,* Adult Endocardial Fibroelastosis Following Electric Shock (E. Naguit) 115

Dickstein, Joseph S., *jt. author,* Repeat Cesarean Section in a Low Socio Economic Population (M. Brown, J. Zackler, and S. Abel) 118

DOCTOR'S NEWS 52, 139, 265, 343, 437, 523

Drugs in the Management of Learning and Behavior Disorders in School Children (J. G. Millichap) 322

Drugs, Control of Habit Forming **(SPECIAL ARTICLE)**

E

EDITORIALS
- Socialized Law (T. R. VanDellen) 21
- The Polar Controversy (T. R. VanDellen) 133
- Against Medical Advice (T. R. VanDellen) 185
- Medicine In Trouble (T. R. VanDellen) 358
- Unnecessary Surgery (T. R. VanDellen) 415
- History of the *Illinois Medical Journal* (T. R. VanDellen) 485
- The Role of the Social Worker in the Community Hospital (J. F. Hinkamp) 529

Electrical Alternans, see M. K. Dayhem

EKG OF THE MONTH, 64, 134, 186, 334, 413, 525

Epigastric Pain and Vomiting With or Without a History of Trauma, see **PEDIATRIC PERPLEXITIES**

Endocardial Fibroelastosis, see E. C. Naguit

F

Failure of Corticosteroid in the Treatment of Duchenne (Pseudo Hypertrophic) Muscular Dystrophy—Report of a Clinically Matched Three Year Double Blind Study (I. M. Siegel, J. E. Miller, and R. Ray) 32

Farivari, A., *jt. author,* Xanthogranulomatous Pyelonephritis (N. Javadpour) 405

Fernandez, Balbino B., *jt. author,* Thymoma, Erythroid Hypoplasia and Myasthenia Gravis—Report of a case with Ultrastructural Study (C. Hartman) 121

Firor, Hugh, see **PEDIATRIC PERPLEXITIES**

Fluorscopic Studies for Upper Airway Problems, **(PEDIATRIC PERPLEXITIES)** see V. J. Harris

Forearm Replantation, A Case Report of a Two-Year-Follow Up (Z. J. Bilas, H. Labinsky, H. Khazie) 315

G

Gastrointestinal Bleeding, see J. E. Weese

Gibbs, Jack L., *jt. author,* The Non Visualizing Gallbladder (C. A. Barthelemy) 408

Grant, Harry F. **(MEDICAL LEGAL REVIEW)** The New Supplemental Security Income Program, 132

Greenwood, Ronald D., **(HISTORY OF MEDICINE),** Marcus P. Hatfield, The First Pediatrician at Northwestern, 62

H

Handler, Raymond M., *jt. author,* Treating Psoriasis of the Scalp With a New Corticosteroid Lotion (R. S. Medansky) 503

Harris, Vivian J., *jt. author,* **(PEDIATRIC PERPLEXITIES)** Simple Fluroscopic Studies For Upper Airway Problems, (W. Meeks) 335

Hartman, Charles, *jt. author,* Thymoma Erythroid Hypoplosia and Myasthenia Gravis—Report of a Case with Ultrastructural Study (B. F. Fernandez) 121

Hartman, Robert, Rape, 518

Hatfield, Marcus P., The First Pediatrician at Northwestern, **(HISTORY OF MEDICINE)** (R. Greenwood) 62

Health Care, A Perspective of Peripheral (B. D. Reeves, S. McCue, A. Wagner, Jr., and T. W. McElin) 34

Hemofiltration for Schistosomiasis Japonicum (W. Stuart Battle, L. M. Nyhus and C. T. Bombeck) 317

Hill, The Remarkable Dr. **SPECIAL ARTICLE,** 488

Hinkamp, Joseph F., The Role of the Social Worker in the Community Hospital, **GUEST EDITORIAL,** 529

HISTORY OF MEDICINE, Marcus P. Hatfield—The First Pediatrician at Northwestern (R. D. Greenwood) 62

House of Delegates, Action of, 427

HOUSESTAFF NEWS, ILLINOIS, 418, 536

Hughey, Michael **(ILLINOIS HOUSESTAFF NEWS)** Death of Moonlighting, 418; A New Voice For Housestaff, 536

Huret, Judy Spector, *jt. author,* Speech Therapy For the Mildly Dysphasic Patient: When is it Indicated? (H. B. Betts) 512

Hyperparathyroidism and Pregnancy, see **SURGICAL GRAND ROUNDS**

I

Intussusception in an Adult, see **SURGICAL GRAND ROUNDS**

Ivankovich, A. D., *jt. author,* Cardiovascular Collapse During Gynecological Laparascopy (R. F. Albrecht, B. Zahed and R. F. Bonnet) 58

ISMS GUIDE TO CONTINUING MEDICAL EDUCATION, 74, 148, 272, 364, 412, 534

J

Javadpour, N., *jt. author,* Xanthogranulomatous Pyelonephritis (A. Farivari) 405

Johnson, Hugh A., Rediscovery of Cushing's Forceps, 517

K

Kidney, Tuberculosis of, see **SURGICAL GRAND ROUNDS**

Kumar, Sudarshan, *jt. author,* Electrical Alternans, Case Report and Comments on its Mechanism and Diagnostic Significance, (M. K. Dayhem) 500

L

Labinsky, Harold, *jt. author,* Forearm Replantation, A Case Report of a Two Year Follow-up (Z. J. Bilos and H. Khazie) 315

Lake, Fredric, see **PRESIDENT'S PAGE**

Lashof, Joyce C., The Illinois Program of Early Periodic Screening Diagnosis and Treatment What is it? **(SPECIAL ARTICLE)** 268

Lawrence, A. G., *jt. author,* Angiosarcoma of the Liver (T. G. Lee) 324

Lee, Timothy G., *jt. author,* Angiosarcoma of the Liver, (A. G. Lawrence) 324

Lees, William M.. Snap, Crackle and Pop! **SPECIAL ARTICLE,** 326

Lithium Carbonate in the Treatment of Manic-Depressive Disorders, see P. A. Mueller

Liver, Angiosarcoma of, see A. G. Lawrence

Love, Leon, **(VIEWBOX)** 56, 136, 333, 414

M

Manic Depressive Disorders, see P. A. Mueller

Meckel's Diverticulum, (K. M. Berkley) 125

Medansky, Roland S., *jt. author,* Treating Psoriasis of the Scalp With a New Corticosteroid Lotion, (R. M. Handler) 503

MEDICAL LEGAL REVIEW, The New Supplemental Security Income Program (H. F. Grant) 132

MEDICHEK—The Illinois Program of Early Periodic Screening Diagnosis and Treatment—What is it? **(SPECIAL ARTICLE)** Joyce C. Lashof, 268
Meeks, Wrophas, *jt. author,* **(PEDIATRIC PERPLEXITIES)** Simple Fluoroscopic Studies For Upper Airway Problems (V. J. Harris) 335
MEMBERSHIP FORUM, 277
Miller, Joseph E., *jt. author,* Failure of Corticosteroid in the Treatment of Duchenne (Pseudo-Hypertrophic) Muscular Dystrophy—Report of a Clinically Matched 3 year Double Blind Study (I. M. Siegel and R. Ray) 32
Millichap, Gordon J., Drugs in the Management of Learning and Behavior Disorders in School Children, 322
Mueller, Patricia A., *jt. author,* Lithium Carbonate in the Treatment of Manic Depressive Disorders: A Follow Up Study (E. A. Wolpert) 505
Muscular Dystrophy, see J. E. Miller

Mc

McCue, S., *jt. author,* A Perspective of Peripheral Health Care (B. D. Reeves, A. Wagner, Jr., and T. W. McElin) 34
McElin, T. W., *jt. author,* A Perspective of Peripheral Health Care (B. D. Reeves, S. McCue, A. Wagner, Jr., and T. W. McElin) 34

N

Naguit, Efren C., *jt. author,* Adult Endocardial Fibroelastosis Following Electric Shock (H. Dexheimer) 115
Neuromuscular Dysfunction of the External Urinary Sphincter, (N. Sadoughi and I. M. Bush) 497
New Supplemental Security Income Program, The—A Prospectus for the Medical Community (Harry E. Grant) 132
NEW PHARMACEUTICAL SPECIALTIES, Paul DeHean, 144, 190, 412, 537
Nyhus, Lloyd, *jt. author,* Hemofiltration for Schistosomiasis Japonicum (W. S. Battle and C. T. Bombeck) 317
Nurseries, Common Problems in High Risk. (Rosita S. Pildes) 47

O

OBITUARIES, 83, 155, 286, 373, 440, 545

P

Parietal Cell Vagotomy, see **SURGICAL GRAND ROUNDS**
PEDIATRIC PERPLEXITIES, Ruth A. Seeler, Editor
Acute Yellow Phosphorus Rat Posioning (R. H. Brown) 128
Simple Fluroscopic Studies For Upper Airway Problems (V. J. Harris and W. Meeks) 335
Epigastric Pain and Vomiting With or Without A History of Trauma (H. V. Firor) 526
Physical Therapy, Prescribing **(SPECIAL ARTICLE)** 350
Pildes, Rosita S., Common Problems in High Risk Nurseries, 47
Polar Controversy, see **EDITORIALS**
Porkorny, William J., *jt. author,* Treatment of Children With Burns (J. G. Raffensperger) 352
Prescribing Physical Therapy **(SPECIAL ARTICLE)** 350
PRESIDENT'S PAGE
Conspiracy of Silence? (W. Scrivner) 10
It's Up To You (W. Scrivner) 95
The Physician-Public Defender of American Health (W. Scrivner) 171
We Must Write Next Chapter of Anti-Substitution Saga (F. Lake) 300
Double Trouble (F. Lake) 392
It's Your Committee and It's Your Future (F. Lake) 477
Psoriasis, see R. S. Medansky
Psychological Value of the Sport, Curling, The, (T. N. Davis) 37
Perspective of Peripheral Health Case, A., (B. D. Reeves, S. McCue, A. Wagner, Jr., and T. W. McElin) 34
Probable 16 Year Course In A Patient with Thrombotic Thrombocytopenic Purpura (D. C. Boswell and G. Sierra) 29
PHYSICIAN RECRUITMENT, 80, 152, 283, 370, 441, 542
PULSE OF THE DOCTOR'S WIFE, 72, 150, 279, 362, 416, 532

R

Raffensperger, John G., *jt. author,* Treatment of Children With Burns, (W. J. Pokorny) 352
Rape, R. Hartman, 518
Rat Poisoning, Acute Yellow Phosphorus, see **PEDIATRIC PERPLEXITIES**
Rao, Sudha, *jt. author,* **(PEDIATRIC PERPLEXITIES)** Acute Yellow Phosphorus Rat Poisoning (R. H. Brown) 128
Ray, Robert D., *jt. author,* Failure of Coricosteroid in the Treatment of Duchenne (Pseudo-Hypertrophic) Muscular Dystrophy—Report of a Clinically Matched 3 Year Double Blind Study (I. M. Siegel, and J. E. Miller) 32
Rediscovery of Cushing's Forcepts, H. A. Johnson, 517
Reeves, B. D., *jt. author,* A. Perspective of Peripheral Health Care. (S. McCue, A. Wagner, Jr. and T. W. McElin) 34
Repeat Cesarean Section in a Low Socio-Economic Population (J. Dickstein, M. Brown, J. Zackler and S. Abel) 118
Replantation, Forearm, see Z. J. Bilos
Resolutions, Action on, 431
Romanus, Raymond J., Abdominal Wall Abscess in an Infant, 515

S

Sadoughi, Nader, *jt. author,* Neuromuscular Dysfunctions of the External Urinary Sphincter (I. M. Bush) 497
Scrivner, Willard, see **PRESIDENT'S PAGE**
Seeler, Ruth A, Editor,/**PEDIATRIC PERPLEXITIES**
Siegel, Irwin M., Failure of Corticosteroid in the Treatment of Duchenne (Pseudo-Hypertrophic) Muscular Dystrophy—Report of a Clinically Matched 3 Year Double Blind Study (J. E. Miller and R. Ray) 32
Sierra, Gregorio, *jt. author,* Probable 16 Year Course in a Patient with Thrombotic Thrombocytopenic Purpura (D. C. Boswell) 29
Simmons, Robert, *jt. author,* Brown Recluse Spider Bite, Increasing Incidents in Northern Illinois (John W. Curtin) 43
"Snap, Crackle and Pop!" **(SPECIAL ARTICLE)** 326
Social Worker, see J. F. Hinkamp
Speech Therapy, see J. S. Huret

SURGICAL GRAND ROUNDS (John M. Beal, Editor)
Tuberculosis of Kidney 68
Intussusception in an Adult 274
Parietal Cell Vagotomy, 338
Cecal Volvulus, 410
Hyperparathyroidism and Pregnancy, 520

T

Tan, Kong Men, **(ILLINOIS HOUSESTAFF NEWS)** *jt. author,* Death of Moonlighting (M. Hughey) 418
Thrombotic Thrombocytopenic Purpura, Probable 16-Year Course in a Patient (D. C. Boswell and G. Sierra) 29
Thymoma, Erythroid Hypoplosia and Myasthenia Gravis—Report of a Case with Ultrastructural Study (B. Fernandez and C. Hartman) 121
Treating Psoriasis, see R. S. Medansky
Treatment of Children with Burns, (J. G. Raffensperger and W. J. Pokorny, 352
Tuberculosis of Kidney, see **SURGICAL GRAND ROUNDS**

U

Urinary Sphincter, see N. Sadoughi

V

Van Dellen, T. R., Editor, see **EDITORIALS**
VIEWBOX (Leon Love, Editor) 56, 136, 333, 414

W

Wagner, A., *jt. author,* A. Perspective of Peripheral Health Care. (B. D. Reeves, S. McCue, and T. W. McElin) 34
Weese, James E Aneurysm of the Gastroduodenal Artery A Cause of Gastrointestinal Bleeding 40
Wolpert, Edward, *jt. author,* Lithium Carbonate in the Treatment of Manic-Depressive D sorders: A Follow Up Study (P. A. Mueller) 505

X-Y-Z

Xanthogranulomatous Pyelonephritis (N. Jawadpour and S. Fairvari) 405
Zackler, Jack, *jt. author,* Repeat Cesarean Section in a Low Socio-Economic Population (J. S. Dickstein, M. Brown and S. Abel) 118
Zahed, B., *jt. author,* Cardiovascular Collapse During Gynecological Laparoscopy (A. D. Ivankovich, R. Albrecht, and R. F. Bonnet) 58

CITIES SERVICE COMPANY
A NATURAL RESOURCE COMPANY

•MEDICAL DIRECTOR

Diversified natural resources company headquartered in Tulsa, seeking qualified full-time Medical Director. Position includes medical department administration and medical services in the corporate headquarters in Tulsa, as well as supervisory administration of medical services in several domestic locations in the U.S. Background in industrial and internal medicine is desirable but not essential. Extensive company benefit plans included.

Please telephone inquiries or send resume to:

P.M. Davis
Cities Service Company
P.O. Box 300
Tulsa, OK 74102

Telephone: (918) 586-2476

An Equal Opportunity Employer M/F

PHYSICIANS WANTED

The Illinois Department of Mental Health invites physicians to apply for challenging positions in its mental health facilities. A comprehensive program of mental health and retardation involving community and inpatient programs is established throughout the State.

Openings are available for physicians who qualify for an Illinois License with approved training in Psychiatry, Internal Medicine or General Medicine.

Salaries for Illinois-licensed physicians range from $26,000 to $44,600 depending upon professional qualifications, experience and capability of assuming increasing professional responsibilities, i.e., Board Certified or Eligible Physician, commencing salary $30,732.

Liberal benefits include life and health insurance, annual and sick leaves, retirement and social security.

Interested doctors should write to the Medical Staff Employment Office, Illinois Department of Mental Health, 160 North LaSalle Street, Chicago, Ill. 60601, or call collect—area code 312, 793-2748 or 2749, hours 9 a.m. to 4:30 p.m.

X75-3228

Illinois medical journal.
v.145, 1974.

4/1/75

DATE | ISSUED TO

X75-3228

Illinois medical journal.
v.145, 1974.

RETURN THIS BOOK ON OR BEFORE LAST DATE STAMPED

OCT 31 '75
RET'D. OCT 29 1975
MAR 7 RET'D
MAR 9 1976
FEB 2 '78
MAY 26 '76
RET'D. MAY 26 '76
RET'D. JAN 26 '78
OCT 26 '76
RET'D OCT 18 1976
MAR 11 '77
RET'D. MAR 17 '77
JUL 12 '77
JUL 5 '77
JAN 19 '78
RET'D. JAN 19 '78